

Assessing Recovery in Total Knee Arthroplasty: A critical narrative review of Muscle Mass, Strength, Physical Performance and Patient Reported Outcome Measures.

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Submitted to: JMIR Perioperative Medicine
on: September 12, 2025

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Abstract

Background: Total Knee Arthroplasty (TKA) is the primary treatment for advanced knee osteoarthritis. Despite its clinical success and favourable Patient-Reported Outcome Measures (PROMs), approximately 20–30% of patients continue to experience persistent functional limitations and muscle weakness. This highlights the need for a comprehensive evaluation of recovery parameters beyond pain and Range of Motion (ROM). Given the wide range of methods available for assessing TKA outcomes, clinicians often select tools based on personal preference and understanding, which may affect accuracy and consistency; for example, the Knee Injury and Osteoarthritis Outcome Score (KOOS) may overestimate function compared to gait analysis studies.

Objective: The aim of this study was to conduct a narrative review focusing on the utility, strengths and limitations of different outcome measures used in routine orthopaedic practice to optimise post-TKA evaluation.

Methods: A literature search was conducted in February 2025 across two databases (PubMed and Web of Science). Eligible studies included original research articles, systematic reviews, and meta-analyses, that focused on validated measures used to evaluate TKA. Case reports, conference abstracts, and studies focused exclusively on surgical techniques were excluded. Themes were identified across studies to structure the results according to types of assessments and clinical applicability.

Results: A total of 6,831 studies were retrieved and screened in this review, with four themes emerging around muscle mass, strength, performance and PROMs. The Oxford Knee Score (OKS) is favoured for its ease of use and minimal ceiling effects. Broader tools like KOOS and Western Ontario and McMaster Universities Osteoarthritis (WOMAC) provide detailed insights but are less practical clinically. For muscle strength, the Portable Fixed Dynamometer (PFD) showed high reliability and comparability to Isokinetic Dynamometry. Dual-energy X-ray Absorptiometry (DXA) remains the gold standard for assessing muscle mass, while Bioelectrical Impedance Analysis (BIA) offers a practical alternative. The Five-Repetition Sit-to-Stand (5R-STs) test effectively evaluates lower limb power and speed.

Conclusions: Clinicians should integrate both objective (muscle mass, strength, performance) and subjective (PROMs) measures to improve TKA recovery assessment. This multidimensional approach not only enhances the accuracy of patient evaluation but also supports the development of tailored rehabilitation strategies that address individual deficits and optimise functional outcomes.

(JMIR Preprints 12/09/2025:84011)

DOI: <https://doi.org/10.2196/preprints.84011>

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Keywords

Arthroplasty, Osteoarthritis, Function, Outcome, Total Knee Replacement

1. Introduction

Osteoarthritis (OA) is a leading cause of pain and disability worldwide, affecting 528 million people

as of 2019 ^{1,2}.

Among various treatment options for OA, TKA stands out for its substantial impact on alleviating chronic knee pain ³. With advancements in prosthetic design and surgical techniques, TKA has demonstrated high survival rates and relatively low complication risks, making it one of the most successful orthopaedic procedures. However, despite these clinical successes, post-operative functional outcomes can vary among patients ⁴, with approximately 20% to 30% experiencing persistent functional limitations and muscle weakness ⁵.

Several factors influence recovery following TKA, including surgeon-related aspects such as surgical volume and technique, as well as patient-related variables like pre-operative physical conditioning and psychological status. Among these, pre-operative quadriceps strength has been identified as a key predictor of post-operative function, directly impacting mobility and the ability to perform daily activities ^{6,7}. Nonetheless, frequently used tools to evaluate TKA in orthopaedics often rely on measures such as pain assessment and ROM ⁸, which, while valuable, may not fully capture post-operative recovery or functional capacity.

Evidence suggests that these metrics correlate poorly with objective measures of physical function and do not adequately reflect muscle weakness or biomechanical impairments that persist post-TKA ⁹. While PROMs provide subjective insights into perceived recovery, they may overestimate functional improvements compared to more objective assessments, such as gait analysis and performance-based tests ¹⁰. This discrepancy underscores the need for a more comprehensive evaluation framework that integrates multiple dimensions of recovery, including muscle mass, muscle strength, and physical performance.

This review aims to critically examine the utility, strengths and limitations of different outcome measures used in routine practice when assessing recovery post-TKA, emphasising the importance of

incorporating objective physical performance metrics alongside PROMs. We hypothesise that a multidimensional approach, combining assessments of muscle mass, strength, physical performance and PROMs, will provide a more accurate and clinically meaningful evaluation of TKA recovery, ultimately guiding more effective rehabilitation strategies.

2. *Methods*

A literature search of studies focusing on methods assessing TKA outcomes was performed using PubMed and Web of Science databases in February 2025. No limits were applied on publication dates. Inclusion criteria comprised original research, systematic reviews, and meta-analyses. After the removal of duplicates and cross-referencing of articles, we screened titles and abstracts for relevance. Studies were excluded if they were case reports, conference abstracts, or focused exclusively on surgical techniques. Only studies utilising standardised and validated assessment tools were included to ensure clinical relevance. The methodological quality of included studies was evaluated based on study design, sample size, and clarity of outcome measures

One author conducted the initial screening of all retrieved abstracts against the inclusion criteria. Full texts of potentially relevant studies were then independently reviewed for eligibility and data extraction. Discrepancies between reviewers were resolved through discussion until consensus was achieved. Extracted data were thematically organised (muscle mass, muscle strength, physical performance and PROMs), allowing patterns across assessment domains to be identified and synthesised into a structured narrative aligned with the review's objectives.

Given the narrative nature of this review, our selection was not strictly systematic; instead, we documented the total number of retrieved and screened articles ($n = 6,831$)

3. Results

.1. Patient Reported Outcome Measures

There are numerous PROMs available to assess the outcomes of TKA, including: Knee Society Clinical Rating System (KSS), WOMAC, KOOS, and the OKS^{11–14}. In clinical practice and research, it is essential to prioritise the use of sound PROMs over frequently used ones. The ultimate goal herein, is to find a balance between standardised measures and specific contextually relevant PROMs in the field of TKA.

The KSS and OKS PROMs are shorter than the KOOS and WOMAC, with ten and 12 items, respectively. The OKS is solely derived from patient input, while the KSS comprises a PROM section completed by the patient and an informational-clinical section for the surgeon. Only the PROM section of the KSS is utilised to produce a psychometrically valid knee score. This separation sought to allow the functional PROM section to be independently assessed from the clinical section and confounding factors such as age or comorbidities. Notably, Martimbianco et al. (2012) reported considerable inter- and intra-examiner variability in the clinical-reported section of the KSS, which raises concerns about its reliability and consistency in clinical use¹⁵. In contrast, the KOOS and WOMAC are larger instruments, with 42 and 33 items, respectively. They assess symptoms, stiffness, pain and activities of daily living (ADL), but also include additional domains such as sports/recreation and quality of life. Like the OKS these instruments are totally focused on the patient and their self-reported experiences.

All four PROMs assess pain and activity function, but they differ in how they capture pain information. The OKS and KSS both include a single item that captures the patient's general level of pain. However, the OKS ask further pain information in the context of general activities, such as

work interference and walking. This is particularly important to assess as movement is associated with changes in pain, from subtle changes in muscle coordination to complete avoidance of joint function¹⁶. In contrast, the KOOS and WOMAC both include a section dedicated to assessing pain experienced during specific activities, with nine identical items. This encourages the patient to recall and report on the pain experience during knee manoeuvres such as knee twisting and straightening. The KOOS is an extension of the WOMAC, which justifies the similarities in the items. It is used in younger and/or more active patients who typically perform demanding twisting movements in their ADL. By assessing knee pain during movements like twisting and straightening, changes in functional outcomes over time can be tracked. This is especially relevant post-TKA, where pain during specific activities is directly linked to the functionality of the joint and the surrounding muscles¹⁷.

The only resemblance when assessing function across the four PROMs is the patient's comfort level when handling stair ascent and descent. This likely reflects the universal importance of these activities in daily life and the significant impact that knee function has on an individual's mobility and well-being. However, each PROM also has unique items that assess different aspects of knee function and quality of life.

The OKS, KOOS, and WOMAC all assess the knee concerning various ADL, such as kneeling, transportation, domestic work, and bathroom activities. The OKS and KSS share only the item related to the distance the patient can walk. The KSS and items within the symptoms section of both KOOS and WOMAC ask about the patient's ability to fully bend and extend the knee, as well as objective measures of flexion contracture and extension lag. The use of similar items and domains across these scores can lead to greater consistency in assessing knee function and symptoms. Furthermore, consistency is important for tracking changes over time and comparing outcomes across different patients and studies. The KOOS is unique in that it assesses ADL related to sports

and recreation and includes items that ask about quality of life. While similarities can provide consistency, differences between PROMs may capture important nuances specific to each condition.

The KSS evaluates four distinct domains: clinical, functional, satisfaction, and fulfilment of expectation. A notable feature is the inclusion of both high-demand tasks and three patient-selected priority activities from a predefined list, aiming to tailor the assessment to individual goals and enhance the relevance of functional evaluation. This patient-led component is designed to offer a more individualised perspective on recovery and may help inform more targeted post-operative rehabilitation. However, despite these strengths, the validity of the KSS has been questioned, particularly in the context of TKA outcome measurement. Several studies have noted limitations, including Ghanem et al. (2010), who highlighted concerns in revision TKA scenarios, and Lingard et al. (2001), who found the system less responsive than broader tools like the SF-36 and WOMAC. One key criticism lies in the item-selection process: patients were not involved in the development of the tool, which may result in content that does not fully reflect patient priorities or lived experiences. Bach et al. (2002) further noted that the relatively limited item pool may constrain the scale's ability to capture the full spectrum of functional outcomes. This lack of patient input and limited item scope could contribute to a misalignment between what the tool measures and what matters most to patients, ultimately impacting its content validity and clinical utility¹⁸⁻²⁰.

Ghanem et al highlight that two very different patients could receive the same clinical score on the KSS¹⁸. For instance, a patient with a stiff, pain-free, well-aligned knee and a patient with mild pain, excellent knee motion, and normal alignment may both receive a similar score, even though they have very different levels of function in their daily lives. To address these claims, a revised Knee Society Scoring System (2011-KS Score) was developed and validated as a more reliable measure for assessing outcomes in TKA procedures^{21,22}. Albeit, a revised outcome measure, PROMs have

inherent limitations in that they rely primarily on self-reported data, which may not always align perfectly with objective measures of physical function. This is where muscle function analysis could come into play. It offers an objective assessment of a patient's physical capabilities, including muscle strength, range of motion, and muscle activation patterns. By quantifying these aspects, healthcare providers can validate and complement the patient's self-reported symptoms and limitations with tangible data. This objective information not only supports the patient's reported experiences but also provides a more complete picture of their health status.

Despite its validity issues the KSS is still popular amongst clinical-researchers ²³, perhaps for including alignment and ROM measurement. Proper coronal alignment of the components in TKA has been shown in the literature to be critical for implant survival rate. Additionally, knee ROM is a crucial indicator of successful TKA and is necessary for many activities of daily living ²⁴. While ROM is commonly measured and reported, the significance of isolated muscle function has been overlooked here. Capin et al (2022) found quadriceps strength in particular, to be a critical factor in TKA recovery and considered it a rate-limiting step ²⁵. This limited quantification of isolated muscle function is an area that warrant attention and improvement in the care of TKA patients.

The OKS was developed specifically for evaluating the outcomes of TKA ²⁶. The simplicity and shortness of the questionnaire make it an attractive option for researchers and this may in part have contributed to its broad use in cohort studies and joint replacement registers ^{27,28}. Whitehouse et al (2005) criticises this intentional oversimplification of the questionnaire, highlighting the lack of scope and sophistication necessary to accommodate the complex interrelated issues of many patients, such as joint stiffness, muscle weakness and instability ²⁹. To address these limitations, the authors suggested using a combination of assessment tools and methods ³⁰. This could include performance-based functional tests, isolated muscle function tests, muscle mass measurement, and imaging

studies.

Another consideration is that OKS has a high response rate when compared to other PROMs ¹¹, although this is not always consistent ²⁹. Analysis of the National Health Service PROMs data set of 72,154 OKS, concluded that OKS does not exhibit a ceiling or a floor effect at 6 months ³¹. Marx et al, (2005) reported a ceiling effect of 22% at 12 months following surgery, but this could be attributed to patients achieving an optimal outcome rather than a limitation of the OKS ³². Nevertheless, this could indicate that the OKS may be more appropriate for short-term outcomes and might inadequately reflect the long-term burden. Although it has been used in randomised control trials to assess knee arthroplasty long-term outcomes ³³.

The WOMAC (developed in 1982) has undergone multiple revisions since and has been validated for TKA clinical trials ³⁴⁻³⁶, with ceiling effects at 6 months and 12 months for TKA patients ³⁷. The KOOS was an upgrade to the WOMAC to effectively capture the requirements of younger and more active individuals with knee injury or osteoarthritis. Several studies have shown that the KOOS is more sensitive and responsive than the WOMAC in younger or more active patients with knee injury or knee osteoarthritis ³⁸. Roos and Toksvig-Larsen (2003) evaluated the outcome of 105 patients (mean age 71) after TKA and found, 74% of all Sport/Recreation items were considered to be “not applicable” ³⁷. The floor effects of approximately 48% likely reflect the high-demand activities, such as sports and recreation, which may be more relevant for younger, more active adults undergoing TKA.

A systematic review of the literature performed by Collins et al (2016) found; as it was intended, the KOOS's ADL subscale has better content validity for older patients, and Sport/Recreation has better content validity for younger patients ³⁹. Increasing ceiling effects from 6 to 12 months, particularly in the pain domain, may suggest that some patients have reached a plateau in their recovery; But also

raises questions about the sensitivity of the measurement tool.

Several studies have evaluated the performance of different PROMs in measuring outcomes following lower extremity joint replacement surgery. Harris et al (2016) identified the OKS and WOMAC as the best-performing PROMs specific to the lower extremity ⁴⁰. The study assessed the validity, reproducibility, and acceptability of the scoring systems. Similarly, Alviar et al (2011) in their review, found OKS and WOMAC, to be the best PROMs after assessing the quality of patient-reported outcome scoring systems ⁴¹. Collins and Roos (2012) analysed attributes of the 11 most frequently used PROMs for THR and TKA and considered KOOS, WOMAC and OKS to be good PROMs ⁴². These PROMs aid in monitoring progress, guiding interventions, and facilitating shared decision-making. Nevertheless, there are limitations, such as the risk of subjective bias and variability in interpretation. Patient responses may be influenced by personal perceptions, mood, cognitive state, or cultural differences. Obtaining consistent and accurate data can be challenging, especially if patients struggle to recall specific details over time. To gain a more thorough understanding of the impact of TKA, it is crucial to integrate objective measures of muscle strength and functional assessments, particularly in addressing muscle weakness.

3.2. *Strength measurements*

The indirect assessment of muscle function in any of the PROMs may not provide sufficient indication of dysfunction, necessitating a comprehensive analysis of objective assessment tools in TKA (Table 1). To this end, this section will focus on the types of muscle strength assessments that are feasible in a TKA clinical setting.

TABLE 1 HERE

When evaluating muscle function, the measured outcomes commonly include muscle strength and power⁴³. Various methodologies assess these parameters, ranging from manual muscle testing to more complex and expensive isokinetic assessments. However, no general consensus exists regarding the preferred method of assessing muscle function in orthopaedic practice, as each approach has distinct advantages and limitations⁴⁴.

1) Isometric Contraction: Isometric strength assessment measures the maximum force generated during a contraction in which the muscle length remains constant (Figure 1(a)). Although isometric contractions are relatively uncommon in daily activities, their clinical relevance lies in their ability to predict functional capacity, particularly in elderly individuals and those with significant functional impairments⁴⁵. Furthermore, isometric strength assessments have demonstrated high reliability across different orthopaedic populations⁴⁶. Isometric strength assessments can be easily performed using a dynamometer or force plate and the individual is instructed to push or pull against an immovable object. PFD have demonstrated high reliability (ICC>0.90) and validity in measuring strong muscle contractions such as knee extension⁴⁷⁻⁴⁹. Importantly, studies have shown that knee muscle strength measurements using a PFD highly correlate with those obtained from an IKD, making PFD a viable alternative for clinical assessment⁵⁰.

Toonstra and Mattacola 2013⁵¹ compared the reliability of IKD, PFD, and Handheld Dynamometry (HHD) for isometric knee strength assessment. Their findings revealed high test-retest reliability for both IKD and PFD, while HHD showed fair to poor reliability.

The strength of IKD lies in its ability to provide stabilization during testing and standardized

protocols, making it the gold standard. However, PFD demonstrated comparable reliability while offering greater portability, ease of use, and cost-effectiveness. This makes PFD an attractive option for routine clinical evaluations, particularly in settings where IKD is not feasible.

Another key advantage of isometric assessments is their safety. Unlike dynamic strength tests, which involve movement and may place stress on healing tissues, isometric assessments minimise joint strain. This makes them particularly suitable for early postoperative assessments, where patient safety is a priority. Given these benefits, isometric strength measurements serve as a practical and reliable method for monitoring recovery following TKA.

2) One-repetition maximum (1-RM): Muscle strength can also be assessed through the one-repetition maximum (1-RM) test, which determines the maximum load that can be lifted in a single attempt, such as during a squat or leg extension (Figure 1(b)). This method evaluates muscle strength in a more functional and dynamic context, offering insight into the ability to generate force during real-world movements.

Despite its functional relevance, 1-RM testing has limitations. The requirement for specialised equipment (e.g., weights, resistance machines) and the time-intensive nature of testing make it less practical for large patient cohorts⁵². Additionally, 1-RM testing carries a risk of injury, particularly in postoperative populations where patients may not yet be able to safely perform maximal-effort movements. To mitigate this risk, researchers often use submaximal testing protocols to estimate 1-RM values⁵³.

3) Isokinetic Contraction: Isokinetic testing measures muscle strength as the peak torque generated during a contraction performed at a constant angular velocity (Figure 1(c)). This method provides

resistance that matches the individual's effort throughout the range of motion, allowing for maximal force production at different joint angles. Isokinetic assessments are particularly valuable for evaluating muscle imbalances, monitoring rehabilitation progress, and understanding strength deficits following TKA.

Despite these advantages, isokinetic testing has notable limitations. The high cost and lack of portability make it less accessible in many clinical settings^{54,55}. Additionally, isokinetic assessments require specialised equipment and trained personnel, making them impractical for routine postoperative evaluations. The potential for joint irritation and discomfort during testing further limits its suitability for early rehabilitation stages.

A key consideration when choosing between isometric and isokinetic testing is clinical feasibility. While isokinetic assessments provide detailed torque-angle relationships, they are not always necessary for functional recovery monitoring. In contrast, isometric testing provides a simple, reliable, and cost-effective means of assessing muscle strength, making it better suited for routine evaluations.

FIGURE 1 HERE

Lauermann et al. (2014)⁵⁶ compared quadriceps strength assessments using isometric, isokinetic, and 1-RM methods in TKA patients. All three methods showed similar validity in detecting strength deficits, suggesting that isometric testing is an effective alternative to more complex assessments. Similarly, Lienhard et al. (2013)⁵⁷ found comparable test-retest reliability across these methods in TKA patients, reinforcing the viability of isometric assessments in clinical practice.

3.3. Muscle mass measurements

Studies have shown significant correlation between skeletal muscle mass and cross-sectional skeletal muscle area in the extremities with muscle strength or power⁵⁸⁻⁶⁰. Hence, assessing these morphological features could be a good way to gauge muscle function. Furthermore, with certain imaging modalities, it may also be possible to determine the extent of sarcopenia, muscle wasting and the level of fibrosis and fat infiltration – all factors that play a significant role in muscle function.

Computed Tomography (CT) is an imaging modality that was introduced over 50 years ago, as the first clinically accepted tool for body composition measurement and served as a gold standard⁶¹. This method uses X-ray beams to create cross-sectional images of the body, allowing estimation of total body fat, visceral fat, and skeletal muscle mass^{62,63}. Despite its early acceptance and high validity confirmed through cadaver dissection ($r = 0.97$), CT has general limitations such as high costs, the need for skilled technicians, and exposure to radiation^{64,65}. Test-retest reliability was found to be high (1.4%, $r = 0.999$)^{65,66}. However, in current practice, CT is rarely utilised for measuring muscle mass, likely due to its associated limitations and the emergence of alternative, more practical techniques such as the MRI.

The introduction of Magnetic Resonance Imaging (MRI) in the 1980s replaced the CT scan as the gold standard⁶⁷. Its 3-dimensional images of skeletal muscle, fat tissue, and other organs is created by emitting radiofrequency energy from hydrogen atom nuclei in magnetic fields, with signal variations indicating different tissue types^{67,68}. This development brought about high-resolution images without radiation exposure, making it suitable for tracking small changes over time, which is beneficial for intervention and observational studies. Advancements in MRI techniques have notably reduced image acquisition times, and modern scanners can accommodate obese subjects. Validated through post-mortem cadaver studies ($r = 0.97$), MRI exhibits high test-retest and inter-observer reliability (2.9%, $r = 0.99$ and 2.6%, $r = 0.99$) in healthy populations^{65,69}. However, limitations in

clinical and research settings include high costs, the need for technical expertise, space requirements, infeasibility for claustrophobic patients or those with MRI-incompatible implanted devices (e.g., cardiac pacemakers) and standardisation is hampered by the existence of various data acquisition protocols^{64,70}.

DXA has emerged as a strong alternative to the gold standard for assessing body composition, being relatively cheap compared with CT scan and MRI, and easy to perform. Initially designed for measuring bone mineral density, DXA is now widely used for examining overall body composition and muscle mass⁶⁷. DXA operates by utilising two X-ray beams to differentiate between fat, bone, and lean tissue based on their X-ray absorption properties^{71,72}. This technique has shown a high correlation with both MRI and CT in estimating skeletal muscle mass, indicating its reliability ($r = 0.88$ and $r = 0.77\text{--}0.95$, respectively)^{73–75}. Additionally, DXA test-retest reliability for measures of Fat Free Mass demonstrated a high correlation ($r = 0.99$), with low precision errors ranging from below 1% to 3%^{76,77}.

However, DXA does present some limitations. Firstly, it does not directly quantify muscle mass; instead, it calculates lean soft tissue mass or Fat Free Mass based on the different grey tones observed in the DXA scan. Assumptions are made during this calculation, and factors like dehydration and oedema, which can be common in populations with obesity, may interfere with the accuracy of the measurements. Additionally, the lack of standardisation across devices, software packages, and versions can yield different results, affecting the reliability and comparability of measurements. Moreover, while DXA involves less radiation exposure compared to CT, there is still some exposure^{78,79}.

BIA has become widely used for assessing body composition in both clinical and nonclinical settings⁸⁰. BIA operates on the principle that tissues with higher water and electrolyte content, like skeletal

muscle, offer less resistance to the passage of a low-voltage electrical current compared to lipid-rich adipose tissue, such as bone. This conductivity difference is exploited by BIA systems to quantify different body compartments. Measurements obtained along with parameters like sex, age, and body weight are then integrated into population-specific body composition prediction equations^{68,79}. The advantages of BIA stem from its non-invasive nature, cost-effectiveness, and ease of use, but limitations include sensitivity to factors like body position, physical exercise, food intake, hydration status and the need for population-specific equations⁸¹. A study by Buckinx et al (2015), attempted to gauge the reliability of BIA in assessing appendicular lean mass⁸². The results showed high intra-operator reliability, indicated by an ICC of 0.89 when performed by the same operator, and Inter-operator reliability was also relatively high with an ICC of 0.77 when performed by different operators. However, the study revealed a notable discrepancy when comparing appendicular lean mass assessed by DXA and predicted by BIA, as evidenced by a low ICC of 0.37. Importantly, there exists a potential for a significant prediction error at the individual level with BIA, coupled with a systematic positive bias leading to an overall underestimation of lean body mass measurements⁸³. Additionally, hydration status is a frequent confounder in clinical settings, as BIA relies on electrical conductivity that is highly sensitive to fluctuations in body water content, potentially compromising accuracy and limiting its reliability in certain patient populations. Despite these limitations, BIA remains a viable alternative in situations where more precise methods are not feasible.

3.4. Performance measurements

While measurements of muscle mass and function are important for understanding physiological dysfunction and pathology, assessing physical performance is essential. In this context, functional performance-based tests use an individual's body weight as resistance, quantifying performance by the time taken or the number of repetitions completed. Several authoritative groups, including The

Osteoarthritis Research Society International, Rehabilitative Care Alliance, and the American Physical Therapy Association, recommend performance-based measures for individuals with osteoarthritis and arthroplasty⁸⁴⁻⁸⁶. These measures typically include assessments of gait speed tests, Stair climbing tests (SCT) and Sit-to-stand (STS) tests, each with distinct yet overlapping focuses.

Gait speed tests primarily assess mobility, endurance, and functional independence by measuring the time required to walk a set distance. They are simple, reliable, and highly predictive of overall recovery, fall risk, and mortality⁸⁷. SCTs focus on functional strength, coordination, and balance, as stair negotiation requires greater knee flexion and quadriceps activation than level walking⁸⁸. SCTs are more sensitive to persistent functional deficits than gait speed tests, as stair climbing is often more challenging postoperatively. STS tests, on the other hand, primarily evaluate lower limb strength and endurance by measuring the ability to transition from sitting to standing multiple times within a set duration or repetition count. STS tests strongly correlate with quadriceps strength and are useful for monitoring functional recovery⁸⁹.

While all three measures provide valuable insights into TKA recovery, they differ in their primary focus and clinical applicability. Gait speed and SCTs assess mobility in dynamic movement tasks, while STS focuses on lower limb muscle strength in a controlled, stationary task. Gait speed tests are most effective for evaluating overall mobility and endurance, whereas SCTs are ideal for assessing functional strength and dynamic balance⁹⁰. In contrast, STS tests specifically target muscle power and endurance without assessing walking ability or balance⁹¹. Despite these differences, all three tests share a common goal of evaluating lower limb function and have been shown to be reliable, valid, and responsive to post-TKA functional improvements⁸⁵. However, it is worth noting that both gait speed and SCTs may present logistical challenges in smaller clinical settings due to space constraints and increased time requirements for setup and execution, potentially limiting their routine use in busy outpatient environments.

Dobson et al (2013) put forth a set of recommended performance-based measures for individuals diagnosed with hip and knee osteoarthritis or following joint replacement ⁸⁵. This selection was based on expert surveys and systematic reviews, considering the evidence supporting the measurement properties of the tests, their feasibility, scoring methods, and expert consensus. The resulting recommended measures included the 30 second sit-to-stand test (30CST), 40 m Fast-paced Walk Test, Stair Climb Test, Time up and go (TUG), and 6 Minute Walk Test (6MWT). In a subsequent update by Dobson et al (2017), the 10 Metre Fast-paced Walk Test and 20-second stair climb test were suggested as alternatives due to complexities in administering the 40 m Fast-paced Walk and scoring the 11 Step Stair Climb Test ⁹².

A taskforce led by Dr Marie Westby created the Total Joint Arthroplasty and Outcome Measures toolkit to be used before and after arthroplasty which included: 30 second STS, gait speed, stair climb test, single leg stance test, 6MWT, TUG and functional reach ⁹³. Prior to the creation of this toolkit, Zeni et al (2010) developed the Delaware Osteoarthritis Profile, a comprehensive set of tests that have been effectively used to measure functional performance pre and post knee arthroplasty, which include; TUG, SCT and 6MWT ⁹⁴.

While the literature contains numerous tests, the focus here will be on muscle strength performance tests. STS with its versions have been identified by Bergquist et al (2019) in their systematic literature review to be the most appropriate performance-based clinical muscle strength test ⁹⁵.

The 30CST is a component of the Senior Fitness Test and involves counting the number of sit-to-stand repetitions completed within a 30-second timeframe. Individuals who are more than halfway through a repetition at the 30-second mark are credited with completing the final repetition. This test has shown good to excellent reliability, with reliability coefficients of 0.84 and 0.92 reported by

Jones et al (1999) for older men and women retested 2 to 5 days after a baseline test ⁹⁶. The validity of the 30CST is supported by its correlation with "leg-press" strength (0.78 for men and 0.71 for women), as reported by Jones et al (1999).

The 5R-STS test has gained widespread use as either a component of the short physical performance battery or as a standalone assessment tool in numerous studies. This test involves performing five sit-to-stand repetitions from a standard chair (44-48 cm height), with timing commencing upon a specific command or the initiation of the first movement and ending when the fifth stand-up is accomplished or when the patient sits down following the fifth stand-up ⁹⁷. The reliability of the 5R-STS test has been estimated across ten studies, yielding a coefficient of 0.81, as reported by Bohannon (2011) ⁹¹. The validity of this test as a measure of lower limb functional muscle strength is supported by its strong correlation with knee extension strength, as demonstrated by Lord et al (2002) ⁸⁹. Furthermore, the correlation between performance on the 5R-STS test and the TUG test, as well as gait speed tests, adds further support for its validity, as highlighted by Schaubert and Bohannon (2005) ⁹⁸.

Although the 5R-STS and 30-second STS tests involve identical movements, they are not interchangeable. The 5R-STS indicates lower limb speed and power for those with lower physical function post-TKA, while the 30-second STS measures lower limb endurance for those with higher physical function ⁹⁹.

4. Discussion

A range of assessment tools is available to evaluate recovery following TKA, each with distinct advantages and limitations. This review highlights the utility, strengths, and constraints of these

measures and recommends a comprehensive, multidimensional evaluation framework. Such an approach enhances the accuracy and clinical relevance of recovery assessments by triangulating data across patient-reported outcomes, strength measures, functional performance, and muscle mass.

Among muscle mass assessment techniques, DXA remains the gold standard due to its high precision and reliability. However, alternative methods such as BIA offer a non-invasive, lower-cost option suitable for clinical settings, despite reduced accuracy and sensitivity to minor changes in muscle composition.

PROMs provide valuable insights into patient perspectives. The OKS is widely employed due to its ease of use, absence of ceiling or floor effects in the short term, and extensive validation in clinical research. KOOS, while broader in scope, often demonstrates ceiling effects and higher completion burden. WOMAC overlaps conceptually but lacks OKS's responsiveness in early recovery. KSS combines patient and clinician input but is less feasible for routine use due to scoring complexity and reliance on in-person assessment. OKS offers the optimal balance of validity, efficiency, and clinical utility in TKA follow-up. Nevertheless, PROMs alone do not provide objective strength assessments, which are critical for a comprehensive evaluation.

In contrast, IKD offers precise quantification of muscle strength, yet its high cost and operational complexity restrict its widespread application. As a practical alternative, PFD provides a reliable, cost-effective and portable means of assessing muscle strength, making it highly suitable for routine clinical practice.

Performance-based measures such as the 5R-STS test offer objective, time-efficient insights into lower limb function. Compared to the TUG, 6MWT, or SCT, the 5R-STS requires less space, is less influenced by cardiovascular limitations, and is more feasible for patients with early post-op mobility impairments. It also shows strong correlation with knee extension strength and mobility metrics,

enhancing its predictive utility in post-TKA recovery.

This specific combination OKS, PFD, BIA, and 5R-STS is what we have recommended in post-TKA follow-up (Figure 2) because it balances psychometric validity, clinical feasibility, and comprehensive recovery profiling. It provides a more complete view of TKA recovery than any individual tool. While alternatives like the 6MWT or SCT yield valuable data, their requirements for time, space, or greater cardiopulmonary reserve make them less practical for routine follow-up or for patients with limited mobility or comorbidities. Likewise, the TUG, though simple, primarily reflects balance and walking ability but lacks sensitivity to muscle power or patient satisfaction domains.

Finally, it is important to note that the interpretability and utility of these tools may vary across populations. For instance, sarcopenia, obesity, or cardiopulmonary conditions may skew performance-based results or BIA readings, requiring clinicians to contextualise outcomes based on age, BMI, and comorbid burden. By triangulating across these assessments, clinicians can reduce bias from any single measure and develop more individualised recovery evaluation.

FIGURE 2 HERE

5. *Conclusion*

A multidimensional approach integrating OKS, PFD, BIA, and 5R-STS provides a more accurate and clinically meaningful assessment of TKA recovery. While PROMs offer patient insights, they should be complemented with objective measures to capture functional deficits. This multidimensional approach not only enhances the accuracy of patient evaluation but also supports the development of tailored rehabilitation strategies that address individual deficits and optimise functional outcomes. Future research should focus on validating this integrated module in clinical practice ensuring

broader adoption in routine TKA follow-up. Additionally, further investigation into intrinsic skeletal muscle (mal)adaptations post-TKA may provide valuable insights into factors contributing to long-term functional limitations.

Mandatory statements

Conflict of Interest: None

Source of Funding: None

Acknowledgments: None

Patient Consent: Not applicable

Ethical Clearance: Not applicable

Author Credit Statements: AB Methodology, Formal analysis, investigation, writing-original draft, Visualisation. NM supervision. VM Writing-review & editing. DJP Conceptualisation, Methodology and supervision. All authors approved the final version of the manuscript.

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TABLES:

Table 1: Comparative analysis of outcome measures used in TKA, including patient-reported outcomes, muscle strength, muscle mass, and physical performance tools. Comparison criteria include measurement type, reliability, validity, ease of use, clinical relevance, limitations, and best use case.

Comparison	PROMs (KSS, WOMAC, KOOS, OKS)	Muscle Strength Tests (IKD, PFD, HHD)	Muscle Mass Tests (CT, MRI, DXA, BIA)	Physical Performance Tests (TUG, 6MWT, 5R-STs, SCT)
Measurement Type	Subjective (patient-reported pain, function)	Objective (muscle force output)	Objective (muscle cross-sectional area or mass)	Objective (functional movement performance)
Reliability	High test-retest reliability but can be influenced by patient perception	High reliability but dependent on test consistency and patient effort	High for CT, MRI, and DXA; moderate for BIA (affected by hydration)	High for TUG, 6MWT, 5R-STs
Validity	Valid for subjective function but may not correlate with actual muscle strength or mobility	IKD, highest validity. PFD, good validity with proper fixation. HHD, lower validity	Highly valid for assessing atrophy or hypertrophy	Strong correlation with mobility and functional independence
Ease of Use	Simple, non-invasive, patient-friendly	Requires equipment; portable dynamometers are easier than isokinetic ones	CT/MRI are expensive; DXA is more accessible; BIA is easiest	Quick, requires minimal equipment (e.g., chair, stopwatch)
Clinical Relevance	Useful for tracking patient-perceived recovery	Directly assesses quadriceps and hamstring strength, critical for TKA recovery	Helps detect muscle loss post-TKA, which can affect long-term function	Strong predictor of fall risk, mobility, and independence
Limitations	Subjective, may not reflect real functional capacity	Requires patient cooperation; costly for isokinetic dynamometers	Expensive (CT, MRI), radiation exposure (CT, DXA), less precise (BIA)	Can be influenced by patient motivation, fatigue, or comorbidities
Best Use Case	Tracking patient-perceived progress	Measuring post-TKA quadriceps/hamstring recovery	Evaluating long-term muscle loss and sarcopenia	Assessing mobility and real-world function

FIGURES:

Figure 1: Illustration of three common muscle strength assessment methods used in TKA recovery: a) Isometric contraction – muscle generates force without joint movement; b) One-repetition maximum (1-RM) – maximal weight lifted once with proper form; c) Isokinetic contraction – muscle contracts at a constant speed throughout the range of motion using a dynamometer.

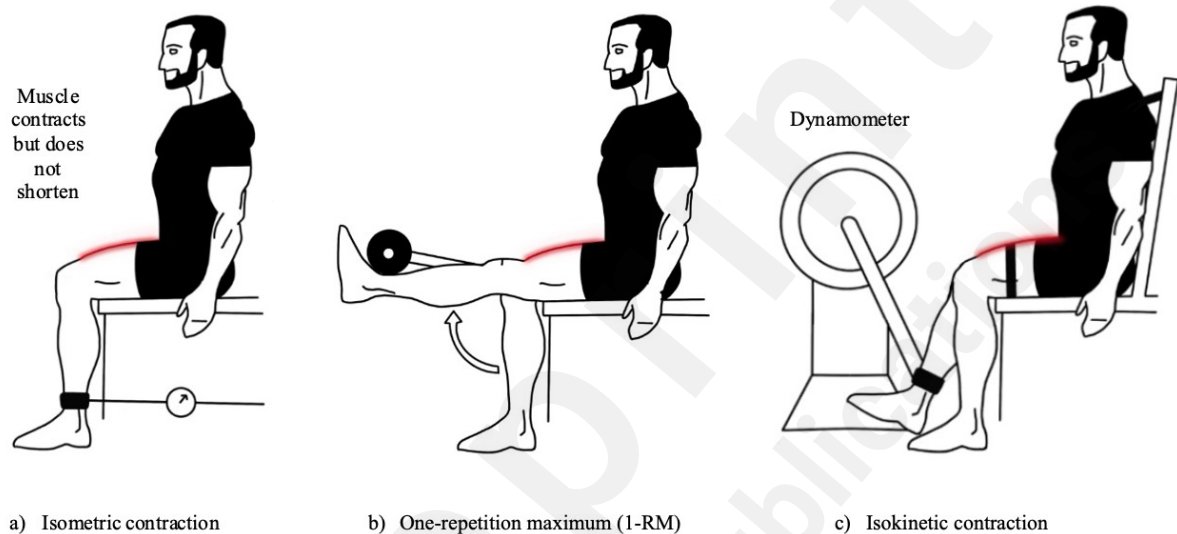


Figure 2: Clinical workflow algorithm for integrating recommended outcome measures throughout the TKA pathway. The flowchart outlines the timing and selection of assessment

tools from the pre-operative assessment appointment to the final follow-up.

Pre-operative assessment Signed consent and collection of baseline data	Outcomes PFD BIA OKS 5R-STS	
Procedure Total knee arthroplasty Enhanced recovery programme		
Follow-up 3 months post TKA		
Follow-up 6 months post TKA		
Follow-up 12 months post TKA		