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Original Research

Diagnosis, Rehabilitation, and Return to Sport after Athletic Hamstring Injury: An ICCUS Society Consensus Statement

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Background

Athletic hamstring injuries (AHSI) remain a persistent challenge because recurrence is common and clinical decisions often depend on incomplete evidence. This consensus statement is intended to give clinicians a practical, unified framework for classification, rehabilitation, and return to sport after athletic hamstring injury. The purpose of this study was to achieve expert consensus on the management of athletic hamstring injuries through a structured, scientific survey approach.

Study Design

Delphi Survey

Methods

A modified Delphi process, aligned with CREDES guidelines, was conducted with an expert panel of sports physical therapists identified as having specific expertise in AHSI from the ICCUS Society. Consensus was defined a priori as at least 80% agreement or disagreement on a 5-point Likert scale. Statements addressed three areas: AHSI examination and classification, rehabilitation and management, and return to sport (RTS) testing.

Results

Sixty statements were developed across three domains. Seventeen experienced clinicians completed the final round. Overall, 54 statements reached consensus, with a mean Likert score of 4.56 ± 0.37 out of 5 (strongly agree), and mean agreement of 89.88% ± 12.1%. Experts supported standardized terminology, MRI and the use of diagnostic ultrasound for diagnosis when appropriate, individualized and criterion-based rehabilitation, progressive tissue loading and length restoration, early neuromuscular control, gradual running and agility progression, progression to pain-free sprinting, objective strength assessment, sport-specific workloads, and athlete readiness as key RTS criteria.

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Discussion

The findings emphasize active rehabilitation guided by measurable progress rather than reliance on fixed thresholds. Clinicians should combine injury classification, functional presentation, symptom response, objective testing, sport demands, and athlete confidence when advancing rehabilitation and making RTS decisions.

Conclusion

This ICCUS Society consensus statement offers a practical roadmap for managing AHSI: classify clearly, load progressively, monitor symptoms, test objectively, and return athletes only when sport-specific running, sprinting, strength, training tolerance, and readiness align.

Level of Evidence

4

INTRODUCTION

Hamstring strain injuries represent a significant burden in athletic populations, posing challenges regarding epidemiology, time lost from sport, high rates of reinjury, and financial implications.[1] While the prevalence of these injuries is well-documented, establishing a unified standard of care across the continuum of recovery remains a priority for sports medicine professionals.

To address complex clinical questions where definitive evidence may be conflicting or incomplete, expert consensus is frequently sought. The Delphi method is a widely accepted, structured, and scientific approach that transforms individual opinions into group consensus through an iterative, multistage process.[2] This flexible method uses group facilitation to aggregate expert judgment effectively. While previous Delphi studies have addressed hamstring injuries, they have largely focused on prevention, or return to sport (RTS), or have been limited to specific populations, such as European soccer.[3] Notably, there is a lack of comprehensive consensus specifically regarding the rehabilitation phase of management.

Therefore, the purpose of this study was to achieve expert consensus on the management of athletic hamstring injuries (AHSI) through a structured, scientific survey approach. The specific aim of this study was to synthesize expert opinions to provide clinical recommendations for the examination and classification, rehabilitation, and return to sport testing for athletes with hamstring injuries.

METHODS

STUDY DESIGN

This study utilized a modified Delphi approach to survey a panel of experts. This design was chosen to provide a structured, scientific means of gathering and refining expert opinion. The methodology and reporting for this study were conducted in accordance with the Conducting and Reporting of Delphi Studies (CREDES) guidelines.[4] Institutional Review Board (IRB) approval was obtained through Franciscan Missionaries of Our Lady University prior to data collection (2025-040-FranU).

PARTICIPANTS

The study involved a multi-tiered participant structure involving a lead researcher, a specialized workgroup, and a larger panel of experts. All participants were members of the ICCUS Society, a multidisciplinary group of physical therapists, athletic trainers, sports scientists, and academics representing expertise in various sports, recognized as experts in sports rehabilitation based on at least 10 years of experience and contributions in research and education.

Lead Researcher: One sports science researcher, a physiotherapist and athletic trainer with over 30 years of research experience, served as the impartial coordinator. This individual facilitated balanced discussion and managed the Delphi process but did not participate in the survey or voting to avoid bias.

Workgroup: A panel of nine physical therapists and athletic trainers from the ICCUS Society with specific expertise in hamstring injuries (spanning high school, collegiate, and professional sports) collaborated with the primary investigator to develop the initial consensus statements and refine the manuscript.

Expert Panel (ICCUS Society Members). The survey was distributed to all 54 members of the ICCUS Society. To be eligible for inclusion, participants were required to be licensed sports medicine practitioners (Physical Therapists, Athletic Trainers, MD/DO, or Chiropractors) with at least 10 years of clinical practice. Additionally, participants must have self-identified as having regular experience examining and treating athletes with primary and recurrent hamstring injuries in high school, collegiate, semi-professional, or professional settings. Individuals lacking this specific experience or those declining to participate were excluded.

PROCEDURES

The study proceeded through a preparatory phase followed by iterative survey rounds. (See Appendix A) Consensus was defined *a priori*. Agreement was defined as a rating of 5 (strongly agree) or 4 (agree), and disagreement as a rating of 2 (disagree) or 1 (strongly disagree). A statement was considered to have reached consensus if 80% of respondents agreed (4 or 5) or disagreed (1 or 2). Items achieving this threshold were accepted and removed from subsequent

rounds. If a statement did not reach the pre-established 80% consensus, it was evaluated by the Workgroup for potential modification based on a qualitative analysis of open-ended participant comments and presentation in a subsequent round.

Preparatory Phase: The Workgroup first convened via video conference (ZOOM) to identify key domains and areas of interest. They were divided into three subgroups focusing on: (1) Management (Classification/Clinical Examination/Imaging), (2) Rehabilitation (Principles/Progression/Interventions), and (3) Return to Sport testing (Programs/Progression/Criteria). Each subgroup submitted 15 to 25 draft statements based on their expertise.

Round 1: The Workgroup reviewed, refined, and established the feasibility, relevance, and importance of these statements to create the consensus statements for the larger panel to assess. Workgroup members were provided with an explanation of any changes made to statements in response to previous feedback, including the rationale for those modifications.

Round 2: Electronic questionnaires were administered using REDCap (Research Electronic Data Capture) to the Workgroup. (See Appendix B) Workgroup members completed the survey and provided feedback to enable query refinements.

Round 3: The REDCap survey was sent to the general ICCUS membership via email link. Only members who met the inclusion criteria participated in the survey. All responses were anonymous, and automated email follow-ups were utilized to ensure adherence and compliance.

Rounds 4-5 (if necessary): If an item did not receive the *a priori* consensus level of 80%, the items' feedback was reviewed by the Workgroup, who then decided to either reword the item or discard it from the next round.

DATA ANALYSIS AND CONSENSUS DEFINITION

Demographic data regarding age, sex, primary profession, and years of experience were first collected. For the consensus statements, participants rated their agreement using a 5-point Likert scale (5 = strongly agree, 1 = strongly disagree) or indicated "no experience". Responses marked as "no experience" were excluded from the analysis.

RESULTS

The first round, including nine workgroup members, yielded 60 statements across the three domains (13 for classification, 25 for rehabilitation and management, and 22 for return to sport). In the second round, all workgroup members participated (n=9), and each statement received >80% consensus, advancing it to the next round for the larger ICCUS membership. Minor changes were made to the statements based on open-ended comments from the survey. The third round sent to all ICCUS members resulted in 17 expert participants (ages 59.9 +/- 10.2 years) meeting the inclusion criteria. Table 1 provides the demographics of expert participants.

Table 1. Demographics of expert participants

Gender	Male	15
	Female	2
Years Experience	15-19	1
	20-24	2
	25-29	2
	>29	12
Setting	Outpatient Clinic	8
	University/School	5
	Sports Team	3
	Other	1

Table 2 provides the average Likert scores for each statement and the percentage of agreement (>80%) after Round 3. The average Likert score was 4.56 +/- 0.37 for agreement, with 89.88% +/ 12.1% consensus.

After Round 3, six statements did not meet the *a priori* 80% consensus. The six statements that did not reach consensus included one from the classification section, two from the rehabilitation section, and three from the return to sport section. Table 3 presents statements that did not reach 80% agreement and the raters' comments. These statements and their comments were reviewed by the Workgroup, which decided not to revise the statements and to remove them from the survey; therefore, the survey ended after Round 3.

DISCUSSION

Hamstring injuries are prevalent in many sports, leading to frustration among athletes and sports medicine providers. While previous researchers have reported consensus statements regarding AHSI, none have provided a comprehensive consensus that includes rehabilitation. A group of sports rehabilitation experts with experience managing AHSI completed a modified Delphi survey to reach consensus on statements across three areas of interest: classification, rehabilitation, and return to sport. A total of 60 statements were evaluated by 17 experts. Fifty-four statements across the three areas reached consensus after three rounds.

EVALUATION AND CLASSIFICATION

Overall, classification reached consensus in 12 of 13 statements (92%). The expert panel reached a high level of consensus on the requirements for a standardized AHSI classification system, with unanimous agreement (100%) that such a framework must utilize standardized terminology with MRI and diagnostic ultrasound as the preferred imaging tools. There was strong agreement (93–94%) that a definitive system is necessary to differentiate between specific muscles and distinct tissue types, such as fascial, muscular, intramuscular tendon, and free tendon injuries, to ef-

Table 2. Consensus Results after Round 3.

Number	Statement	Average Likert	Agreement %
Section 1: Athletic Hamstring Injury (AHSI) Evaluation and Classification			
Characteristics of Acute Hamstring Injury Classification			
1	One definitive classification system is needed for AHSI.	4.59	93
2	An AHSI classification system should have agreed terminology.	5	100
3	An AHSI classification system should be able to differentiate between muscles.	4.71	94
4	An AHSI classification system requires clear parameters, such as (but not limited to) anatomical and radiological classification, free tendon versus central tendon.	4.65	88
5	An AHSI classification system should differentiate between fascial/muscular/Intramuscular tendon and free tendon injuries.	4.47	94
6	The mechanism of AHSI should be included in the classification system (where appropriate/ known).	4.41	81
Imaging in ASI classification			
7	The primary classification tool of AHSI is the BAMIC (British Athletic Muscle Injury Classification).	4.24	81
9	Imaging is necessary in an AHSI classification system.	3.94	81
10	MRI is the preferred imaging tool for AHSI diagnosis and classification.	4.69	100
11	There is a role for diagnostic ultrasound in the diagnosis and classification of AHSI.	4.93	100
Utility of ASI classification			
12	An AHSI classification system most effectively guides management.	4.31	94
13	The classification of AHSI relates to recovery time and return to performance.	4.5	94
Section 2: Athletic Hamstring Injury Rehabilitation and Management			
Guiding Principles			
1	Rehabilitation of AHSI should be based on a combination of the functional presentation and objective classification of the injury.	5	100
2	A thorough history, including mechanism of injury, location of pain, history of previous injury (recurrence), and functional limitations, should guide AHSI rehabilitation.	5	100
3	Clinicians should take an individualized approach to treating AHSI within functional performance and presentation.	4.87	93
4	A multidisciplinary approach is most effective in treating AHSI.	4.67	87
5	Mild pain is permissible during AHSI rehabilitation but should not exceed a level 2-5 (scale 0-10) and should symptoms subside within 24 hours.	4.33	87
6	Chronic or recurring AHSI should be treated differently from acute, 1st-time injuries, taking care to ensure that other components of the injury are identified and not overlooked or optimally addressed during the primary/initial event.	4.67	93
General Progression			
7	AHSI rehabilitation should utilize specific quantitative and qualitative criteria to progress exercises from phase to phase and return to training and play.	5	100
8	AHSI rehabilitation should be progressive in tissue loading.	4.93	100
9	AHSI rehabilitation should be progressive in restoring tissue length.	4.87	100
Specific Interventions			
10	Immediate, light range of motion is necessary for grade I & II AHSI.	4.87	100
11	Isometric contractions should be initiated immediately following grade I & II AHSI.	4.53	93
12	Concentric muscle loading should progress to eccentric loading, i.e., Nordic hamstrings during AHSI rehabilitation.	4.8	100
13	Muscle loading should progress to ballistic (plyometric) loading near the end of AHSI rehabilitation.	4.33	80
14	Neuromuscular control and proprioceptive exercises should be included early for AHSI for optimizing lumbopelvic and trunk control.	4.67	93
15	Neural/dural gliding should be included in an AHSI rehabilitation program due to possible involvement of the sciatic nerve.	4.73	100
18	If available, shockwave modalities and class IV laser therapy are beneficial during the AHSI rehabilitation process.	4.07	80

Number	Statement	Average Likert	Agreement %
19	Soft tissue techniques (such as Instrument Assisted Soft Tissue Mobilization) are beneficial during the AHSI rehabilitation process.	4.33	80
Running and Agility Progression			
20	A gradual running program can be an important part of an AHSI rehabilitation program.	4.73	93
21	Patient reported outcome measure (PROM) scores should show >70- 80% before running or sprinting commences.	4	80
22	Running dosage, duration & intensity should be gradually increased after AHSI toward full sprinting.	4.93	100
23	Pain-free running is a criterion for returning to sprinting following AHIS.	4.73	100
24	Sprinting dosage loads should be consistent with sport-specific intensities and volumes during AHSI rehabilitation.	4.87	100
25	Sport-specific agility is a significant part of an AHSI rehabilitation program.	5	100
Section 3: Athletic Hamstring Injury Return to Sport (RTS)			
Characteristics of return to sport programs			
1	RTS after AHSI should be a multidisciplinary process that involves all stakeholders.	4.87	100
2	Strength and function of the kinetic chain should be considered for RTS after AHSI.	4.93	100
4	Strength peak force/torque of hamstrings should be evaluated for RTS after AHSI.	4.93	100
5	Endurance capacity of the hamstrings should be evaluated for RTS after AHSI.	4.4	80
6	Benchmarks for strength should reflect the sport-specific demands of the athlete/sport for RTS after AHSI.	4.6	87
7	Athlete self-assessment of their readiness to RTS is a key factor in the RTS decision- making process.	4.67	93
Return to sport progression			
8	Progression to peak isometric force in mid and outer range should be considered for RTS after AHSI.	4.4	87
9	Progression to peak isotonic strength (eccentric only/eccentric and concentric) should be considered for RTS after AHSI.	4.73	93
10	RTS dosages should be increased incrementally (gradually) to ensure a safe return to given activities after AHSI.	5	100
11	RTS dosages should approach game-level intensities and volumes to reduce the risk of recurrence of AHSI.	4.73	100
12	The use of previous GPS metrics can guide the required dosage of appropriate metrics (volume, sprints, speeds, high-speed running) for RTS after AHSI.	4.71	87
13	Feed forward activities must be pain-free and completed before feedback activities for live scrimmages and RTS are implemented.	4.47	93
Return to sport criteria			
14	Sprinting should be pain-free for RTS after AHSI.	4.87	100
17	Lower extremity strength should be within 10% of previous data or population means for RTS after AHSI.	4.53	96
18	Athletes should be able to complete full, unrestricted training sessions for RTS after AHSI.	4.73	96
19	The athlete subjective apprehension should be assessed for RTS after AHSI.	4.93	100
Future Research			
20	Future research should investigate types (styles) and dosages of running (quantity, speed) that promote adaptations but reduce the risk of recurrence of AHSI.	4.4	80
21	Future research should investigate safe time frames to return to running after AHSI based on injury classification.	4.27	80
22	Future research should investigate which functional test best determines safe RTS after AHSI.	4.6	87

fectively guide clinical management and predict recovery timelines.

While 81% of experts agreed that the British Athletic Muscle Injury Classification (BAMIC)[5] is a primary tool and that imaging is generally necessary, the panel did not reach consensus on the statement, "Anatomical classification using radiological assessment is essential in diagnosing AHSI." While they agreed that radiological assessment (ultrasound/MRI) can identify tendon involvement, the experts noted that clinical palpation and "hamstring mapping" often provide sufficient diagnostic utility without

Table 3. Statements not reaching 80% agreement, with rater comments.

Section	Statement	Comments
Classification	8. "Anatomical classification using radiological assessment is essential in diagnosing AHSI."	*-Literature shows strong prognostic value of anatomical location (e.g. central tendon, proximal free tendon) but hamstring mapping has shown to have good prognostic utility without radiologic assessment* *-Palpation and anatomical comprehension will allow you make a quality clinical impression but make not be able to tell full amount of direct and indirect damage to the area without a scan* *-Clinicians need to be able to practice without the need for expensive imaging*
Rehabilitation	16. "Biofeedback monitoring is beneficial during the AHSI rehabilitation process and should be used to compare bilaterally."	*-Not sure if this is beneficial or not.* *-What type of biofeedback? and not sure biofeedback is the best normative comparison in all situations* *-Have not used this for the last 50 years has not influenced outcome* *-EMG biofeedback? Interesting but that would be experienced based not evidence based. We use torque feedback to progress intensity of eccentrics is an isokinetic centric protocol. But a lot of patients do have this option.*
	17. "If available, dry needling should be used to reduce symptoms and improve flexibility after AHSI."	*-That's helping the patient feel better not getting the patient better.* *-Illegal for PTs in California* *-If available, dry needling should be used to reduce symptoms and improve flexibility after AHSI. Maybe make [the statement] softer. 'Dry needling may be used as an adjunct treatment in AHSI if allowable.'*
Return to Sport	3."If available, EMG force decay rates should be evaluated for RTS after AHSI."	*-I'm intrigued. Using EMG on a case by case basis to guide progress of hamstring function after a tear! I can see that a study might show a problem in an adequate same using EMG but to then use EMG in single cases might be beyond the sensitivity of the measure. But I claim ignorance on the utility.* *-If available*
	15. "The hamstring to quadriceps strength ratio should be greater than 60% for RTS after AHSI."	*-Not sure about this. Not sure if this is being tested mainstream.* *-I have not used this measure but not saying it's wrong or shouldn't be used. I just haven't used it. I have not used this measure but not saying it's wrong or shouldn't be used. I just haven't used it* *-Conventional (concentric to concentric) or functional (eccentric hamstring compared to concentric quads)* *-What speed of testing; Depends on speed of testing* *-Ratio is test specific within an athlete and sport specific between athletes. What if the ratio is bad on the involved and noninvolved sides*
	16."Hip and knee range of motion should be within 10% of previous scores, or 20% of the opposite limb, for RTS after AHSI."	*-Range of motion should be symmetrical.* *-Agree with 10% of previous scores. Don't agree with 20% of opposite limb* *-Specifically active or passive ROM?* *-Never see this as an issue. They may have ROM/flexibility issues independent of the injury that are worrying but I will not factor that into the RTS decision.* *-May differ based on limb dominance*

imaging. This can be especially beneficial in environments where advanced imaging is not available.

REHABILITATION AND MANAGEMENT

The expert panel reached consensus on 23 of 25 items (92%), covering rehabilitation principles, progression, and AHSI interventions. They emphasized evidence-based progression over emerging technologies or adjunctive therapies not readily available to many clinicians. The experts emphasized a program individualized to the athlete (93%) as well as a multidisciplinary (87%) approach to ASHI rehabilitation, with unanimous (100%) agreement that programs must be guided by a thorough clinical history and a combination of functional and objective measures. Rehabilitation should be defined by a structured, criterion-based progression (100%) that advances in both tissue loading and length restoration, using a pain-monitoring model in which mild symptoms (2-5/10) are permissible if resolved within 24 hours. Initial interventions should focus on immediate light range of motion (100%), early isometrics (93%), and neuromuscular control (93%), eventually transitioning from concentric to eccentric loading (100%) and late-stage ballistic plyometrics (80%). The final phase of recovery centers on a gradual running and agility program (93-100%) that progressively increases in intensity until the athlete achieves pain-free sprinting at sport-specific volumes. Notably, while several adjunct therapies, such as shockwave and soft-tissue techniques, were supported, the panel did not reach consensus on the necessity of biofeedback monitoring or dry needling, reflecting a clinical preference for active, evidence-based progressions over emerging or less accessible technologies.

RETURN TO SPORT TESTING

The experts evaluated 22 statements on RTS after AHSI, covering characteristics, progressions, and criteria. They reached a consensus on 19 items (86%). Overall, the expert panel determined that RTS after an athletic hamstring injury must be a multidisciplinary approach focused on the strength and function of the entire kinetic chain. Unani-

mous consensus was reached on the importance of evaluating hamstring peak force or torque to guide progression of the athlete to full, unrestricted training sessions and pain-free sprinting at intensities and volumes that approach game-level demands. The panel emphasized a gradual, criterion-based progression to guide dosage. Experts placed significant weight on the athlete's psychological readiness, including their self-assessment and the absence of subjective apprehension.

While experts prioritized objective benchmarks, they did not reach consensus on the use of fixed metrics such as a standard 60% hamstring-to-quadriceps ratio, specific range-of-motion percentages, or EMG force decay rates. The panel cited concerns regarding clinical sensitivity and the lack of sport-specific context in these metrics. They noted that ratios are highly specific to testing (concentric or eccentric) and may be influenced by limb dominance and pre-existing limitations.

STRENGTHS AND LIMITATIONS

A key strength of this study is its expert review process: a specialized workgroup refined statements before a larger panel of experienced clinicians evaluated them. The expert panel possessed a high degree of clinical expertise, with the majority (12 of 17) having over 29 years of experience in sports medicine covering high school, collegiate, and professional sports. Furthermore, this study addresses a significant gap in the literature by providing a comprehensive consensus including the rehabilitation phase, which has been frequently overlooked in previous Delphi studies.

Despite these strengths, several limitations must be acknowledged. The final expert panel size was relatively small (n=17), which may limit the perspectives represented. Because the panel was recruited exclusively from the ICCUS Society, the results may not be fully generalizable to all sports medicine practitioners globally.

RECOMMENDATIONS FOR FUTURE RESEARCH

The expert panel identified several areas for future research to bridge the gap between consensus and evidence-based practice in AHSI. Researchers should investigate time frames to return to running based on specific injury classifications and anatomical locations. Studies on functional outcomes may help determine which functional tests or batteries best determine a safe and successful return to sport. Further investigation into the clinical sensitivity of emerging technologies, such as EMG force decay rates, may help determine their utility in individual management.

CONCLUSION

This modified Delphi study of sports rehabilitation experts established consensus on the classification, rehabilitation, and return to sport criteria for athletes with hamstring injuries. This study provides a standardized framework that prioritizes objective clinical testing, criterion-based active rehabilitation, and multifactorial return to sport testing. Implementing these recommendations can help clinicians reduce the significant burden of hamstring injuries by providing more consistent, evidence-based care throughout recovery. Future work will provide practical guidance to help clinicians implement these findings.

DISCLOSURE

During the preparation of this work, the authors utilized AI (NotebookLM) to assist in drafting and refining the narrative sections. This process utilized a detailed research outline and specific consensus data provided by the authors. The authors reviewed and edited the output to ensure clinical accuracy and adherence to the study's findings. The authors take full responsibility for the final content of the manuscript.

CONFLICTS OF INTEREST

The authors affirm that they have no financial affiliation that has direct financial interest in any matter included in this manuscript.

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SUPPLEMENTARY MATERIALS

Appendix A

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Appendix B

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