Perspective

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Stroke Rehabilitation Take the Effectiveness of Physical Treatments after Stroke For Granted

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Description

The majority of the hard evidence, however, does imply that stroke patients benefit from rehabilitation with physiotherapy. This benefit may be statistically small, but for a given individual, it could mean the difference between living at home or in an institution. Few studies address the question of the optimal physiotherapy in stroke rehabilitation. The evidence available today suggests that it does not matter which form of treatment is chosen and that any of the available approaches will improve the patient's functional status. In other words, if an optimal treatment exists, we have, so far, failed to identify it. Until further evidence emerges, we should therefore select therapies that are most cost-effective and that can be given to the largest number of patients. Well-planned clinical trials aimed at finding the best approach and discriminating potential responders from nonresponders are urgently needed. Owing to a scarcity of clinical research, evidence-based clinical guidelines are not available to guide physiotherapy rehabilitation after total knee replacement surgery. This is despite the fact that, annually, over 20 000 patients in Australia, over 300 000 patients in North America and 36 000 patients in the UK potentially require rehabilitation at this time to regain functional independence and to resume recreational and work-related physical activities. This survey of clinicians aimed to describe standard (usual) care after total knee replacement in Australia and to provide possible explanations for practice variance, if such variation exists.

Purposive Sampling

A nationwide postal survey involving public and privately funded hospital physiotherapy departments was conducted. Purposive sampling was used to randomly select hospitals from the National Joint Replacement Registry. A series of closed and open-ended protocol-based questions were asked. A response rate of 65% (65/100) was obtained. Elements of consistency and diversity across the acute and post-acute phases were evident. Consistent findings included the provision of gait retraining and exercise prescription in the acute period, the requirement for independent ambulation as a criterion for discharge from acute care and the routine referral to ongoing outpatient or community-based physiotherapy. Less consistency was reported for the use of continuous passive motion and cryotherapy in the acute phase, the modes of ongoing rehabilitation, discharge from rehabilitation criteria and the tools for measuring outcomes. Both institutional and non-institutional factors appeared to explain the demonstrated practice variation. In order to propagate evidence-based practice guidelines and uniformity in care, well-designed clinical trials are required to identify cost-effective rehabilitation programmes after total knee replacement. A consensus was obtained on 16 theoretical beliefs; however the evidence base underlying these beliefs remains sparse. Many of these beliefs require further debate within the physiotherapy profession such as the amount of time spent on preparation for function, the automatic translation of movement into function, carry over outside therapy, and the way in which tasks should be practised.

Glenoid Margin

Sixty-one patients were consecutively included, block randomized into two groups, and stratified according to gender and hemiplegic site. Group 1 (33 patients) and group 2 (28 patients) had physiotherapy according to Motor Relearning Programme (MRP) and Bobath, respectively. The supplemental treatment did not differ in the two groups. Patients treated according to MRP stayed fewer days in hospital than those treated according to Bobath (mean 21 days versus 34 days, p = 0.008). Both groups improved in MAS and SMES, but the improvement in motor function was significantly better in the MRP group. The two groups improved in Barthel ADL Index without significant differences between the groups. However, women treated by MRP improved more in ADL than women treated by Bobath. There were no differences between the groups in the life quality test (NHP), use of assistive devices or accommodation after discharge from the hospital. Massive rotator cuff tears provide a challenge for effective rehabilitation. Work has been ongoing at Torbay Hospital, Devon since 2000 to develop an exercise programme for the management of this patient group. This programme has been evaluated in a pilot study and a further randomised controlled trial is currently taking place which will enable us to estimate the treatment effect. This paper discusses the background to the development of the rehabilitation programme, the programme itself and the results of the pilot study. The pilot study was an evaluation of the rehabilitation programme. Patients identified through primary and secondary care referrals to physiotherapy with a clinical diagnosis of a massive rotator cuff tear underwent an

ultrasound scan to confirm the diagnosis. A massive cuff tear was one where the leading edge of the tear had retracted past the glenoid margin. The clinical diagnosis was based on the presence of some or all of the following signs: positive humeral thrust on elevation, gross weakness and wasting of supraspinatus and infraspinatus, infraspinatus lag and rupture of the long head of biceps. Eligible patients were invited to take part in the study and informed consent was obtained. The baseline assessment was carried out and then the patient undertook the treatment programme. Outcome measures were reassessed 12 weeks from the baseline assessment.