patient-group follows a 4-week programme (4 days a week) including motor rehabilitation (balance, gait, effort reconditioning...), interviews with a social worker, support groups with a psychologist, relaxation, and spa bath therapy. An initial assessment based on the Unified Parkinson’s Disease Rating Scale – completed by the doctor, a physiotherapist, an occupational therapist, and a psychomotor therapist– is achieved 10 days before the programme launching. That assessment is a tool to homogenise the constitution of groups or to redirect some patients to an individual management. On day one it is enriched by a 6-Minute-Walk test (physical education teacher), a Timed Get Up and Go test (physiotherapist or psychomotor therapist), and a SF-36. The final assessment uses the same tests 15 days after the programme end. Due to interruptions of management, only 14 files could be treated: 9 men and 5 women with a mean age of 64 years. Little difference between the tests before–after was pointed out. For instance, concerning the SF36, the one-sided Wilcoxon signed-rank test for paired-data pointed out an increase of the physical score at the significance limit ($P$ slightly superior to 0.05) whereas no increase of the mental score was pointed out.

The level of dependence represents a limit as TPE concerns only patients able to walk and free from severe mind impairment. On the one hand the variability of the disease hampers the setting up of homogeneous groups. On the other hand some patients leave the group because of fatigue and/or evolution of the disease. The little size of the workable files results in a lack of statistical power: cf. evolution of physical score in SF36. The final assessment 15 days after the programme end seems not relevant and should be done 4 months after the programme end. Other ideas have to be explored: creation of a TPE programme involving the patient’s relatives, looking for partnership with nearby associations to maintain at home the activities initiated during the program, and intervention of an “expert-patient”.

Further reading
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Strength improvement after 3 months of resistance training among Parkinson’s disease patients

M. Demonceau a,*, M.C. Rodrigues de la Cruz a, F. Naveau a, J.-L. Croiser c, D. Maquet a, G. Garraux b
a Département des sciences de la motricité, université de Liège, allée des sports, 4000 Sart-Tilman, Belgium
b Centre de recherches du cyclotron, CHU de Liège, Liège, Belgium
*Corresponding author.
E-mail address: m.demonceau@ulg.ac.be

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Objectives.– To assess the feasibility and the effects of a strengthening program for people with Parkinson’s disease (PD).
Methods.– Fourteen patients with Hoehn and Yahr stage [1] < III of PD were allocated to either 24 sessions of strength training (ST group; n = 8) or to a control group (C group; n = 6) for 3 months. Concentric knee muscle strength and a maximal cycling incremental test were performed at baseline and after training. Training consisted of progressive resistive exercises on leg press, leg extension, leg curl, between 50 and 80% of 1RM and was completed by non-instrumented exercises for trunk and upper limbs muscles. Anxiety, depression and quality of life were assessed using questionnaires. An Anova for repeated measures was used for statistical analysis.

Results.– Six patients of the ST group (75%) fully completed the program. There were significant “group by time” effects for all knee muscles strength measures of less involved side ($P < 0.05$). A significant “group by time” effect was also found for knee flexors of the most involved side, but only at angular speed of 180°/s ($P = 0.03$). Patients of ST group also increased maximal aerobic power (+13%) whereas patients of C group decreased their performances (−9%; “group by time” effect, $P = 0.04$). No changes in anxiety, depression or quality of life could be highlighted.

Conclusions.– The increase of some strength measures in ST group showed that progressive strength training counteracts strength decrease among people with Parkinson’s disease. Strengthening also had a positive effect on maximal aerobic power.

Reference
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