Stroke

Oral communications

CO0200
Active mobility early after stroke. A randomised controled trial (AMOBES)
Alain Yelnik1,∗, Cedric Andriansifanetra1, Peggy Reinert1, Mathilde Evrand1, Hélène Marneff1, Marie Wanepain1, Margaux Barbie1, Johann Beaudreuil1, Jean Pascal Devailly2, Eric Vicaut3
1 GH Lariboisière F. Widal, MPR, Paris, France
2 GH Paris Nord-Val-de-Seine, MPR, Paris, France
3 GH Lariboisière F. Widal, AP–HP, université Paris Diderot, unité de recherche clinique, Paris, France
∗Corresponding author.
E-mail address: alain.yelnik@lrb.aphp.fr (A. Yelnik)

Objective Active and intensive physical therapy (PT) facilitates motor recovery when provided at a subacute stage after stroke. The efficiency of very early intensive PT (within the 2 first weeks) has been much less investigated. Early intensive rehabilitation might be beneficial for neural plasticity but also detrimental by worsening the cerebral ischemia. The AVERT study (Bernhardt 2015) showed negative effect of high dose of very early mobilisation.

Material/Patients and methods Patients have been recruited in this multicentre randomized controlled trial (9 stroke units with PRM teams) to compare “soft” (20 min/day apart from respiratory needs) versus “intensive” PT (idem + 45 minutes of intensive exercises/day), initiated within the 72 first hours after a first hemispheric stroke. Blind assessment has been made. The primary criterion was the motor control assessed by the Fugl Meyer score at D90. Secondary criteria were: Fugl Meyer at D15, D30, D45, postural balance (postural assessment scale for stroke), autonomy (rankin and functional independence measure) at D15, D30, D45, D90, unexpected medical events, length of hospital stay, quality of life (stroke impact scale) at D90. The study has been approved by the local ethics committee n° 2011/37, registered on clinical trial.gov NCT01520636.

Results One hundred and three of the 104 included patients could be analysed, 64 males, 67 right hemispheric lesions, 80 ischemic lesions, NIHSS<8 in 19 patients, 8-15 in 42, >15 in 42; age 66.2 ± 13/67.2 ± 11. No significant difference between groups was observed for the primary criterion (median: 41.5 [14;76] versus 54 [22;80], p = 0.32), neither for any of the secondary criteria. The number of unexpected medical events was the same in the two groups.

The sub-group analysis, for the primary as for the secondary criteria, according to the 3 groups of severity, the side of the lesion, thrombolysis, or type of stroke did not show any difference.

Discussion - Conclusion The results of the RCT (AMOBES) confirm previous studies. Very early intensive exercises after stroke are not more effective on motor recovery than a soft PT preventing immobility related complications.

Keywords Stroke; Early physical therapy; Intensity

http://dx.doi.org/10.1016/j.rehab.2016.07.155

CO0201
Predictors of motor outcomes in severe sub-acute stroke patients after upper limb intensive combined (robot-mediated + usual care) training
Christophe Duret∗, Anne Gaelle Grosmaire, Ophélie Courtial
Centre Hospitalier Sud Francilien - Neurologie, Corbeil Essonne, France
∗Corresponding author.
E-mail address: ch.duret@les-trois-soleils.fr (C. Duret)

Objective In stroke patients, motor impairments evaluated during the first few weeks usually predict upper limb motor outcomes after rehabilitation. However, a recent growing literature suggests that severe patients might not follow this principle[1]. This study aimed at exploring predictors of motor recovery after intensive training in that sub population of stroke patients.

Material/Patients and methods Thirty-eight patients with sub-acute hemiparesis (19 females, age 56 ± 17 [19–87] years; time from stroke, 55 ± 22 days) carried out 16 sessions (33 ± 12 days) of robot-assisted adaptive training using a shoulder/elbow device integrated into conventional care. Motor outcomes were assessed using the Fugl-Meyer Assessment (FMA) scale and kinematic measures at baseline and after treatment. Potential predictors were baseline neurological, cognitive (i.e. aphasia and neglect scores) status and kinematic measures. Age, gender, type of stroke, time since stroke, side of paresis and duration of training were also collected. Statistical analyzes explored potential predictors of motor changes and of favorable changes (Minimal Clinical Important Difference [MCID]).

Results Analyzes didn’t show any clinical predictor of motor outcomes. Moreover, baseline patients’ clinical characteristics did not predict clinically important improvement. Baseline kinematic