for 1426 days of hospitalization (mean hospital stay 40 days) for 6.15 rehabilitation sessions/week/patient (92% for neurological conditions including 43% for stroke). Eighty-one percent of the patients came from regular hospital wards (97% from acute care and rehabilitation units). At discharge from home care, 92% of patients had achieved the rehabilitation objective set at the time of admission: 35 patients were satisfied (no response available for 2 patients); 28 pursued their rehabilitation with a private practitioner, 4 attended day hospital clinics and 2 were rehospitalized.

The HCG is a complement to usual hospital rehabilitation care. In our experience, this home care follows logically the patient’s care programme after a full hospitalization by offering a coordinated programme of home care. The HCG pools the strengths of existing facilities allowing a rapid development of a full hospitalization by offering a coordinated programme of home care. The EPICES score could be useful to organize patient discharge.

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Self-rehabilitation program of fatiguing series of maximal contraction exercises in chronic peripheral facial paresis

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Introduction.— As of today there are no methods validated to promote recovery in patients with chronic (i.e. beyond one year post onset) peripheral facial paresis (PPF). This study reports on the effects of a self-rehabilitation program designed to optimize the synaptic plasticity phenomenon.

Methods.— Eleven consecutive patients (8F; age 45 ± 7 years) with chronic stable PPF of various etiologies were followed for at least two months while undergoing a self-rehabilitation program comprised of a fatiguing series of daily bilateral muscle contraction exercises of maximum intensity focused on 3 essential facial muscle groups: frontalis, zygomatic, and orbicularis oculi. Each contraction attempt was to be maintained for at least 3 seconds with a pause of 1 second or less before the next contraction. At each visit the patients had to give the therapist a written record of the exercises (specifying in particular the number of contractions up to the fatigue in each series) they had performed prior to the visit. A single-blind evaluation before and after training was based on the “Creteil Scale” (CS) that we designed to rate 12 muscle groups from 0 to 3 (maximum score 36) on video recordings of facial testing.

Results.— The etiologies for PFP were idiopathic, tumoral, iatrogenic, traumatic, and congenital. One patient had bilateral PFP (12 hemifaces rehabilitated). The average PFP onset to treatment time was 13 ± 12 years and the mean duration of the rehabilitation treatment was 4 ± 2 months. Mean CS score improved from 17.3 ± 3.2 to 19.3 ± 3.4 (P < 0.001). Nine patients reported having done their exercises but only two provided written records.

Discussion.— High number repetition of maximal-intensity exercises and fatigue induction are three essential conditions for optimal involvement of nervous system plasticity. Patients with chronic PFP improved facial motor function within only four months of treatment, regardless of the amount of time since PFP onset, using self-rehabilitation treatment involving fatigue-inducing series of maximum intensity contraction exercises.

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