CO59-004-e

Incobotulinumtoxin A (Xeomin®) injected with flexible intervals is a well-tolerated long-term treatment of cervical dystonia

J.-M. Coulon
Service de MPR, hôpital Sébastopol, 48, rue de Sébastopol, 51090 Reims, France
E-mail address: jmoulon@chu-reims.fr

Keywords: Cervical dystonia; Incobotulinumtoxin A; Flexible intervals

Background.– Long-term management of cervical dystonia (CD) involves repeated botulinum toxin injections at around 3-month intervals. Many patients and physicians may prefer shorter intervals but it is assumed that this might increase the risk of adverse events (AEs) and neutralizing antibody formation. We analyzed the clinical need and safety of flexible injection intervals with Incobotulinumtoxin A (Xeomin®, NT 201), a purified botulinum toxin type A free from accessory (complexing) proteins.

Methods.– Post-hoc analysis was carried out using data from a randomized, double-blind, placebo-controlled phase 3 study with a randomized, double-blind extension period. Subjects with CD (pretreated or botulinum toxin treatment naïve) could receive ≤ 6 Incobotulinumtoxin A treatments with fixed doses (120 or 240 U) but flexible intervals (> 6 weeks). Re-injection occurred when subjects and physicians agreed on the need and subjects had a Toronto Western Spasmodic Torticollis Rating Scale Total score of when subjects and physicians agreed on the need and subjects had a Toronto Western Spasmodic Torticollis Rating Scale Total score of ≥ 20. Standard safety assessments were performed throughout.

Results.– Two hundred and fourteen subjects entered the extension period (120 U dose group, n = 103; 240 U dose group, n = 111). In total, 821 incobotulinumtoxin A injections were included in this analysis: 369 (44.9%) given at 6–11 week intervals and 452 (55.1%) at 12–20 weeks intervals. Frequency and severity of AEs were similar, irrespective of injection intervals (< 12 weeks versus ≥ 12 weeks), with no cumulative effects of repeated treatment. As would be expected in CD, the most frequent AEs were free from accessory (complexing) proteins.

Discussion.– Incobotulinumtoxin A (Xeomin®), injected at flexible intervals according to subjects’ clinical needs, is effective and well tolerated in the long-term management of CD.

http://dx.doi.org/10.1016/j.rehab.2013.07.1019

CO59-005-e

Reliability of the goniometric measurement of ankle dorsiflexion in hemiparetic patients

Hôpital Raymond-Poincaré, AP–HP, 104, boulevard Raymond-Poincaré, 92380 Garches, France
*Corresponding author.
E-mail address: popoff.mel@gmail.com

Introduction.– The equinus foot deformity is common in hemiparetic patients. Although widely used, the reproducibility of goniometric measurement of ankle dorsiflexion is little studied and variable. The objective was to evaluate the intra/inter-rater-reliability of this measure, and to evaluate a new method of goniometric measurement of ankle dorsiflexion in hemiparetic patients.

Methods.– Prospective, monocentric study; all hemiparetic patients due to a recent brain injury, hospitalized during the study period were included. Goniometric measurements of ankle dorsiflexion were performed on both healthy and hemiplegic sides, by four judges, and repeated a week later. Landmarks were either free (corresponding to the evaluators’ usual practice) or imposed. The conventional method evaluated the equinus on the hemiparetic side. The S. Index was defined as the difference between the dorsiflexion on the hemiparetic side and the hemiplegic side, by four judges, and repeated a week later. Landmarks were either free (corresponding to the evaluators’ usual practice) or imposed.

Results.– Thirty-four patients were included (88% stroke patients). Intra-rater ICC was good for the classical method (0.72 to 0.78) and ranged from mediocre to moderate for the S. Index (0.43 to 0.70) with imposed landmarks; it ranged from very bad to moderate (0.22 to 0.66) for the S. Index with free landmarks. Inter-rater ICC was moderate (0.62) for the classical method (free or imposed landmarks) at day 1 and day 7; it was mediocre with imposed landmarks at day 1 and day 7 (0.44 and 0.56) and moderate at day 1 and day 7 (0.52 and 0.56) for the S. index.

Discussion.– This study confirmed that the intra and inter-rater reliability of goniometric measurements of equinus were not satisfying, whatever the method. Therefore, the search for a method that has better metrological qualities is necessary. Intra-rater reliability was better with conventional method and free landmarks; however, one coefficient was correct for one judge with the new method, which has to be improved.

http://dx.doi.org/10.1016/j.rehab.2013.07.1020

CO59-006-e

Spasticity vs cocontraction of triceps surae, tibialis anterior paresis and locomotion in chronic hemiparesis

M. Ghedira , I.-M. Albertsen, N. Bayle, J.-M. Gracies, E. Hutin
Laboratoire d'analyse et restauration du mouvement, service de rééducation neurologomotrice, hôpitaux universitaires Henri-Mondor, AP–HP, université Pierre-et-Marie-Curie, Paris VI, 51, boulevard du Maréchal-de-Lattre-de-Tassigny, 94010 Créteil, France
*Corresponding author.
E-mail address: ghedira.monna@gmail.com

Keywords: Paresis; Spasticity; Tardieu scale; Ankle; Locomotion

Introduction.– In chronic hemiparesis, active ankle dorsiflexion deficit at swing phase is associated with contracture and cocontraction in triceps surae and paresis of tibialis anterior [1]. We aimed to analyze the role of triceps surae spasticity vs cocontraction and tibialis anterior paresis in the hemiparetic gait disorder.

Methods.– Nineteen patients with chronic hemiparesis (45 ± 16 years) participated. The spasticity grade and angle (X11–XCS) of triceps surae (knee extended) and the angle of weakness (X11–A) of dorsiflexion were measured using the step-wise assessment of spastic paresis, including the Tardieu scale [2,3]. Each subject performed a 10-meter barefoot walking test (seated start and arrival) at preferred and maximal speed. Spatial-temporal parameters were quantified: speed, step length and cadence. We explored correlations between spasticity and weakness parameters at the ankle and gait spatial-temporal parameters.

Results.– At preferred speed: speed, 0.69 ± 0.25 m/s; step length, 0.51 ± 0.12 m; cadence, 1.33 ± 0.31 step/s. At fast speed: speed, 1.08 ± 0.40 m/s; step length, 0.55 ± 0.15 m; cadence, 1.91 ± 0.39 step/s. In the paretic ankle: triceps surae spasticity grade, 2.2 ± 0.8; spasticity angle, 13.7 ± 6.5°; dorsiflexion angle of weakness, 13.2 ± 9.3°. At preferred speed, the angle of weakness was negatively correlated with speed (r = –0.48, P = 0.039), step length (r = –0.55, P = 0.014), and at fast speed, with speed (r = –0.56, P = 0.012), step length (r = –0.57, P = 0.010) and cadence (r = –0.47, P = 0.040).

Conclusions.– In chronic hemiparesis, ambulation (at preferred and fast speed), is correlated at the ankle with the combination of tibialis anterior paresis and triceps surae cocontraction rather than with triceps surae spasticity.

References

http://dx.doi.org/10.1016/j.rehab.2013.07.1021

CO59-007-e

Satisfaction with botulinum toxin treatment in poststroke spasticity: Results from a cross-sectional physician survey

© 2020 Elsevier Masson SAS. All rights reserved. - Document downloaded on 28/02/2020 It is forbidden and illegal to distribute this document.