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Mental practice with motor imagery in gait rehabilitation following stroke: A randomized controlled trial

K. Oostra a, A. Oomen b,*, G. Vingerhoets b, G. Vanderstraeten a

a Centre hospitalier universitaire de Gand De Pintelaan 185, 9000 Gand, Belgium
b Département de psychologie de l’université de Gand, 9000 Gand, Belgium
*Corresponding author.

E-mail address: kristine.oostra@ugent.be

Keywords: Stroke; Mental practice; Motor imagery ability; Gait rehabilitation

Introduction. – Recently, mental practice with motor imagery has been increasingly recommended for use in rehabilitation programs following stroke. It has been found effective in improving arm function after stroke [3]. So far, few studies examined the potential effect of mental practice on lower limb function.

In this study, we first wanted to evaluate if motor imagery ability is preserved after stroke. Secondly, we wanted to examine if mental practice in combination with physical practice is beneficial in improving gait function after stroke.

Subjects and methods. – Forty-four subjects with gait dysfunction after a first time stroke, were randomly allocated to a MI (intervention) group (n = 21) and a muscle relaxation (control) group (n = 23). All participants received a standard gait rehabilitation program. Additionally, the motor imagery group received 30 minutes mental practice; the control group received in the same amount of therapist interaction progressive muscle relaxation.

Motor imagery ability was measured using the MIQ-RS [2] and a mental chronometry test [1]. The lower limb function was evaluated using a 10 m test, gait velocity and the Fugl Meyer scale.

Results. – The present findings indicate that patients with stroke have a preserved motor imagery ability. All outcome measures of lower limb function improved after 6 weeks of training regardless of the used regimen. A significant group interaction was seen for the results of the 10 m test and MIQ-Rs.

References

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Effect of a robotic kinematic constraint on hemiparetics gait. Randomized controlled study

C. Bonnyaud a, R. Zory, J. Boudarham, D. Pradon, D. Bensmail, N. Roche

CHU Raymond-Poincaré GRC TH, 104, boulevard Raymond-Poincaré, 92380 Garches, France
*Corresponding author.

E-mail address: c.bonnyaud@gmail.com

Keywords: Stroke; Lokomat®; Restrainment; Asymmetry; Gait training; Biomechanical gait parameters

Background. – To date no study has assessed effects of a robotic-assisted gait training on the kinematic and kinetic gait parameters in hemiparetic patients. Constraint therapy seems an interesting approach in the stroke patients rehabilitation. A robotic constraint gait training would be an innovative paradigm in stroke patients.

Objective. – To compare a new Lokomat® asymmetric restraint paradigm (with a negative kinematic constraint on the non-paretic limb and a positive kinematic constraint on the paretic limb) with a conventional symmetrical Lokomat® training in hemiparetic subjects.

Methods. – Twenty-six hemiparetic subjects were randomized to one of two groups Lokomat® experimental gait training (LE) or Lokomat® conventional gait training (LC). They were assessed using 3D gait analysis before, immediately after the 20 minutes of gait training and following a 20 minute rest period.

Results. – There was a greater increase in peak knee flexion on the paretic side following LE than LC (P = 0.04) and each type of training induced different changes in vertical GRF during single support phase on the paretic side. Several other spatio-temporal, kinematic and kinetic gait parameters were improved after both types of training.

Discussion and conclusion. – Lokomatr® restrained gait training with a negative kinematic constraint on the paretic limb and a positive kinematic constraint on the non-paretic limb appears to be an effective approach to specifically improve knee flexion in the paretic lower limb in hemiparetic patients. This study highlights also spatio-temporal, kinematic and kinetic improvements after Lokomat® training, in hemiparetic subjects, rarely investigated before.

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Evaluation of the quality of sleep in patients with stroke


Service de médecine physique, rééducation et réadaptation fonctionnelle, CHU Fattouma Bourguiba, rue 1er juin, 5000 Monastir, Tunisia
*Corresponding author.

E-mail address: sanasalah@live.fr

Keywords: Sleep disorders; Stroke; Sleep apnea

Aims of the study. – Assessing the quality of sleep of a population of patients suffering from ischemic stroke.

Patients et methods. – Prospective study conducted from December 2012 to March 2013. The data studied were epidemiological and clinical. The assessment of the anxiodepressive profile was made by “The Hospital Anxiety and Depression Scale” (HADS) and the quality of life (QOL). The SF12 was evaluated by “The Short Form 12” (SF12). Sleep quality was assessed using the Epworth Sleepiness Scale, the Pittsburgh sleep quality index (PSQI) and a polygraphic recording.

Results. – We recruited 22 patients, with a mean age of 54.2 years ± 10 years. The sex ratio MF was 2.6. Of these patients, 77.3% had at least one cardiovascular risk factor and 59.1% had 2 risk factors or more. The majority of our patients (95.4%) were hemiparetic. The left hand side was affected in 54.5% of cases. All the patients were anxious and/or depressed (HAD-Anxiety average: 11.5 ± 2.9 and HAD-Depression average: 11.3 ± 3.3). Concerning the QOL, the SF12 physical component score was 33.9 ± 4.3 and the mental component score was 37.3 ± 10.9. The Epworth score average was 8.8 ± 4.4, considered high enough to require a polygraphic recording, the average PSQI was 7.6 ± 3.2. Impaired Epworth score was significantly associated with HAD-Anxiety score (r = 0.4, P = 0.05). A high PSQI was significantly correlated with age (r = 0.45, P = 0.03) and HAD-Anxiety score (r = 0.65, P < 0.001). Sleep apnea was confirmed in 18% of cases.

Discussion. – The relationship between sleep disorders and stroke is already established. Excessive daytime sleepiness caused by sleep apnea or fatigue caused by insomnia have major impact on the patient’s ability to perform rehabilitation program. Screening for these disorders is important to preserve the vital prognosis (secondary stroke prevention) and to improve the functional prognosis.

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Guided self-rehabilitation contracts and gait speed in chronic hemiparesis. A prospective study

N. Khalil a, E. Hutin, T. Santiago, S. Joudoux, J.-M. Gracies

AP-HP, groupe hospitalier Henri-Mondor, université Paris Est Créteil, unité de neuro rééducation, service de médecine physique et de réadaptation, 50, avenue du Maréchal-de-Lattre-de-Tassigny, 94010 Créteil, France
*Corresponding author.

E-mail address: nathalie.kh@gmail.com

Keywords: Spastic Paresis; Guided Self-Rehabilitation Contracts; Walking speed

Background. – Conventional physical therapy (CFT) has no meaningful impact on walking speed beyond 9 months after stroke. For patients with adequate training, in hemiparetic subjects, rarely investigated before.
cognition, we propose Guided Self-Rehabilitation Contracts (GSRC) where the therapist provides double guidance to patients: technical, selecting and explaining the exercises, and psychological, using a contract whereby patients agree to: perform their prescribed daily work and; document this work in writing on a logbook.

Methods.-- Twelve patients with chronic hemiparesis (5 M, 49 ± 5 years, 77 ± 20 months post-stroke, mean ± SEM) were assessed twice 8 weeks apart, undergoing no botulinum toxin injection in the period. In addition to a mean 2 hours weekly of CPT, 6 performed over 3 hours weekly of personal work based on a GSC. Outcome measures included comfortable and maximal walking speed (WS) with shoes, passive range of dorsiflexion (XV1), angle of catch (XV4, Tardieu) and active range of dorsiflexion (A), knee flexed and knee extended.

Results.-- XV1 knee extended was the only parameter different at baseline between the two groups (GSC, 93° ± 4; CPT, 82° ± 1; P = 0.01, Mann-Whitney). Within 8 weeks, comfortable WS increased from 0.77 ± 0.13 to 0.88 ± 0.13 m/s (+14%) in GSRC Group vs from 0.68 ± 0.13 to 0.69 ± 0.13 m/s (+1.4%) in CPT group (P < 0.01, Fisher’s exact test). XV1 increased by 3.3° knee flexed and 5.5° knee extended in the GSC group, and decreased by 0.6° and 4.6° respectively in the CPT group (NS). A knee extended increased by 8.2% in the GSC group and decreased by 8% in the conventional group (NS).

Conclusion.-- In chronic hemiparesis, Guided Self-Rehabilitation Contracts may improve walking speed more than sole conventional physical therapy.

Further reading

Quality of life in stroke patients with aphasia
C. Lucot1, M. Koleck2, K. Laurent1, B. Darrigrand3, J. Bordes4, P.-A. Joseph5, P. Dehail1, J.-M. Mazaux6
1 Université de Franche-Comté, UFR SMP orthophonie, 10 ter, avenue Denfert-Rochereau, 25000 Besançon, France
2 Université Bordeaux-Segalen, EA 4139 santé et qualité de vie, Bordeaux, France
3 Université Bordeaux-Segalen, EA 4136 handicap et système nerveux, CHU de Bordeaux, Bordeaux, France
4 Université Bordeaux-Segalen, EA 4136 handicap et système nerveux, CH de Libourne, Libourne, France
E-mail address: claire.lucot@gmail.com

Keywords: Aphasia; Quality of life; Stroke

Objective.-- Quality of life (QoL) is difficult to assess in stroke patients with aphasia because language impairment limits the use of verbal questionnaires. In a recent meta-analysis, Hilari et al identified some predictors of aphasic persons’ QoL, but data from epidemiological studies are lacking, and whether all dimensions of QoL are affected by aphasia remains unknown.

Methods.-- In context of an epidemiological survey of stroke with aphasia conducted in Aquitaine, France (Lagade et al., 2011), 101 aphasic patients were compared to 154 healthy subjects and 55 matched stroke patients without aphasia. QoL was assessed with the SIP-65 QoL scale, and the Branchholm and Fugl-Meyer’s Li Sat 11, which is a visual, non-verbal analogic satisfaction with life scale.

Results.-- QoL was found significantly lower in aphasic persons than in healthy subjects in all parameters of the SIP-65, excepted feeding, and lower than QoL of stroke patients without aphasia on items assessing fatigue, housing, outdoor activity and moving, communication and leisure.

Patients and methods.-- A questionnaire was sent to 68 LIS patients. The following elements were asked: age, gender, aetiology of LIS and LIS duration, the autonomy for the displacements in electric wheelchair, the communication devices, the medical devices, the occurrence of chronic pain, the possible wish to be euthanized, the wish to be resuscitated in case of necessity. For all the LIS patients the quality of life had been estimated by the Anamnestic Comparative Self Assessment scale (ASCA) who is a self-assessment of the well being, first time in 2007 then again in 2013.

Results.-- Sex ratio: 40men/8women, average age 53 years (28-80), The quality of life of LIS patients had not varied in a significant way after 6 years (P = 0.17). The main aetiologies of LIS were: ischemic vascular accident (56), hemorrhagic vascular accident (two), trauma (seven), others causes (three). The average duration of the LIS in 2013 was of 13.7 years (6–34). The place of life was in 80% residence, in 16% a nursing home and in 4% a rehabilitation center. 60% of LIS lived in couple. Concerning medical devices: 44.1% had a gastrostomy, 31.6% tracheotomy and 12% had a permanent urinary probe. 50% had a computer communication device, 57.4% were autonomous in the electric wheelchair. 44.1% had chronic pain, 2.9% had a wish of euthanasia but 64.7% envisaged resuscitation in case of necessity.

Discussion.-- This work demonstrates on one hand that the quality of life of the LIS patients is preserved and that on the other hand it remains in the time. Factors which can explain this fact are: living in the place of residence, the life in couple, the access to communication devices, the help for displacements by electric wheelchair by the addition of adapted interfaces.

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