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 W, 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 CPT group (NS).

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

Further reading
Gracies JM. Autoprise en charge du membre supérieur chez l’hémiplégique :

Aim– QoL are affected by aphasia remains unknown. Analysis, Hilari et al identified some predictors of aphasic persons’ QoL, but language impairment limits the use of verbal questionnaires. In a recent meta-analysis, 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.– 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 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: 40 men/8 women, 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% had a tracheostomy 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% agreed to: perform their prescribed daily work and; document this work in writing on a logbook.