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 login.

**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 ($\text{X}_\text{Vf}$), angle of catch ($\text{X}_{\text{Vc}}$, Tardieu) and active range of dorsiflexion (A), knee flexed and knee extended.

**Results.** $\text{X}_\text{Vf}$ knee extended was the only parameter different at baseline between the two groups (GSC, 93° ± 4°; CPT, 82° ± 1°; P = 0.11, 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). $\text{X}_\text{Vf}$ 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**


Evolution after 6 years interval of the quality of life of 68 locked in syndrome patients

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**Keywords:** Locked in syndrome; Quality of life

**Objective.**—Estimate the course of locked in syndrome (LIS) patients’ quality of life in 6 years of interval; all patients had (tetraparesis, needed help facilities in the communication and in the mobilization).

**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: 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 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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