TR04-004-e
Early post-stroke rehabilitation in Portugal
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The Portuguese National Health System is an organized and hierarchized system managing almost all the stroke patients. In Portugal the “Via Verde do AVC” – Stroke greenway – aims that any patient suffering a stroke is assisted in the therapeutic time window for thrombolysis, if that will be the case. The acute phase usually happens in a general hospital and the Rehabilitation Department begins managing the patient as soon as possible. As a rule in the Stroke Units, a PRM physician acts as consultant, on a daily basis. At discharge, if needed, the patient can continue his Rehabilitation treatment, as outpatient, in a clinic near her/his home, or as inpatient. In this situation, the patient goes to a Rehabilitation Centre, for comprehensive (and intensive) Rehab or for the Continuum of Care Network, with four options: Domiciliary Service, Convalescence Unit, Median term Unit and Long term Unit (table). The system is well thought but in most of the hospitals there is no physiatrist in the discharge management team as well as no defined criteria for choosing to which kind of facility the patient should go.

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TR04-005-e
Organization of the rehabilitation after hospitalization in Italy
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Keywords: Stroke; Rehabilitation; Organization; Discharge Rehabilitation pathways after rehabilitation in Italy are very patchy due to the regional autonomy of the single region. The organization range from a mainly private organization with a definite difference from hospital and community, to systems mainly public where the rehabilitation from the hospital to the community in a smooth continuity of care.

In the first case, rehabilitation is provided from the patients himself that buy services. In the second case, the physiatrist decides the appropriate setting at discharge. From the acute hospital the possible setting is: severe brain injury rehabilitation center in the case of an injury with a GCS ≤ 8; moderate-severe stroke to intensive rehabilitation unit; the mild-moderate to the community rehabilitation (home or outpatients). If severe capability is present a low intensity rehabilitation facility is used. In the community, rehabilitation is organized in specific rehabilitation services. The intervention is concentrated on the post acute phase although a part of activity if for the “chronic phase”. A real continuity of rehabilitation between the acute and the post-acute phase without a lengthy waiting list is one of the main goals.

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TR04-006-e
Very early supported discharge in Sweden
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Keywords: Stroke; Early supported discharge

The talk will present the situation of rehabilitation in the home setting in Sweden as well as the early supported discharge. There will be information on the recommendations in Sweden, how many that are getting early supported discharge and how this is organized. Some information will also be given regarding an ongoing study of very early supported discharge. How feasible is this and who is considered suitable to be discharge early and still need rehabilitation?

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TR04-007-e
Early supported discharge after stroke in France
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Early supported discharge is a main challenge after stroke. The length of stay in acute stroke unit then in rehabilitation unit could be shortened, what needs an adapted outpatient organization for rehabilitation care. In France there are 125,000 new strokes per year, among them about 100,000 with physical and/or cognitive consequences lasting more than 24 hours. After the acute stage, 33.8% of the survivors are admitted in an inpatient rehabilitation facility (specialized unit for 10.4%, general or geriatric rehabilitation unit for 23.4%), most of the patients being treated at home or in an institutionalized facility. Physical and speech therapies, but not occupational therapy can be provided at home with national insurance reimbursement. In case of a complex rehabilitation program needed, rehabilitation in daily hospital can be provided. The national plan for stroke 2010–2014 made recommendations to improve the local organization of rehabilitation treatment. A specialized PRM, Neurologist or Geriatric consultation is mandatory within the first year. Mobile PRM units, at least made of a PRM specialist, an occupational therapist and a social worker, in charge of the organization of rehabilitation care from the acute stage to the latest stage at home are encouraged but financing remains an issue.

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Posters

P420-e
Effect of AFO on gait stability and balance control in patients with hemiparetic stroke
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Keywords: Ankle-foot orthosis; Stroke; Gait stability; Balance; Walking capacity

Introduction. – The aim of this study was to quantitatively analyze the effect of ankle-foot orthosis (AFO) on gait stability and to probe the use of AFO to improve walking capacity, gait stability and balance control in patients with post-stroke.

Methods. – A total of 25 inpatients with prior chronic hemiparesis resulting from stroke who could walk at least 10 m without assistance. The maximum walking speed and gait asymmetry index were examined using the motion analysis system. Functional balance was assessed using the Functional Ambulation Categories, Berg Balance Scale and Five-Times-Sit-to-Stand Test.

Results. – The AFO had positive effects on hemiplegic gait parameters, improving walking speed, gait stability and functional balance (P < 0.01). Pair wise comparisons suggested that there were significant differences between using AFO immediately and no only on the maximum walking speed, Functional Ambulation Categories and gait asymmetry index (P < 0.05). After 4 weeks, there were significant differences the walking speed, gait asymmetry index and functional balance control (P < 0.01).