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

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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 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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Evaluation of the quality of sleep in patients with stroke

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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 anxio-depressive profile was made by “The Hospital Anxiety and Depression Scale” (HADS) and the quality of life (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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Effect of a robotic kinematic constraint on hemiparetics gait. Randomized controlled study

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Keywords: Stroke; Lokomat®; Restraint; 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, kinetic and kinematic gait parameters were improved after both types of training. Discussion and conclusion. -- Lokomat® restrained gait training with a negative kinematic constraint on the non-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, kinetic and kinematic improvements after Lokomat® training, in hemiparetic subjects, rarely investigated before.

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

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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
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 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
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Keywords: Aphasia; Quality of life; Stroke

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, Hilarot 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.

Aim. – To provide information on QoL dimensions and predictors in stroke patients with aphasia.

Methods. – In context of an epidemiological survey of stroke with aphasia conducted in Aquitaine, France (Lagadec 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 Branholm 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. Results on the Li Sat-11 showed that aphasic persons were significantly more dissatisfied than healthy subjects in all dimensions of QoL, and significantly more dissatisfied than stroke patients without aphasia in the following parameters: life as a whole, autonomy, leisure, resources, couple and sexual life, relationships with friends, physical as well as psychological well-being. QoL was found related to aphasia severity, functional status as assessed by the Barthel Index, communication activity and mood. Multivariate analysis are on-going.

Discussion and conclusion. – Aphasia impairs all dimensions of QoL, and mostly those involving communication, family life and community participation. This should be taken into account in therapeutic plans and projects, and psycho-social approaches should be developed in aphasia therapy.

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Evolution after 6 years of 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: 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. 50% had a gastrostomy, 80% residence, in 16% a nursing home and in 4% a rehabilitation center. 60% of LIS patients was 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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