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# EJPRM systematic continuous update on Cochrane reviews in rehabilitation: news from the 3rd 4th and 5th Issues of 2010

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***Aim*. Since 2007 we focused our attention as EJPRM to the best available clinical evidence as offered by the Cochrane Collaboration. Due to the absence of a specific Rehabilitation Group (only a Field exists), reviews of PRM interest are in different groups and not easy to find. Consequently, the EJPRM offer the service of listing and presenting all these reviews systematically. The aim of the present paper was to systematically review all the new rehabilitation papers published in the 3rd 4th and 5th Issues of 2010 from the Cochrane Library in order to provide to physicians involved in the field a summary of the best evidence nowadays available.**
***Methods*. The author systematically searched all the new papers of rehabilitative interest in the 3rd 4th and 5th Issues of 2010 of the Cochrane Library. The retrieved papers have been then divided in subgroups on the base of the topic and the Cochrane Groups.**
**Results. The number of included papers was 8, 7 of these were new reviews. Four new reviews deal with neurological rehabilitation, being performed by the Stroke group, 2 with musculoskeletal disorders, 1 with cardiac rehabilitation. Moreover, 1 review from the Back Group the has been updated.**
***Conclusion*. The Cochrane Collaboration and his product, the Cochrane Library, are really relevant instruments to improve EBM in medical practice and thus also in the Rehabilitation Field. The present paper can help Rehabilitation Specialists to easily retrieve the conclusions of the most relevant and updated reviews in order to change their clinical practice in a more rapid and effective way.**

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Knowledge and papers about rehabilitation topics are growing up quite quickly during the last years. Sometimes results are discordant, other times are based on small population, thus limiting the strength of the findings. The best way to obviate to these problems and to synthesize results driving clinical indications is to perform systematic reviews on high interest topic. This is the main aim of the Cochrane Collaboration, so that today the Cochrane reviews are considered the most reliable instruments of synthesis. In order to present to our readers the best available evidence in the field of Rehabilitation, we continuously perform systematic reviews of the articles regularly published in the Cochrane Library.

In the present article readers can find a list of papers of rehabilitative interest systematically researched and reviewed from the 3rd 4th and 5th Issues of 2010. At the end of the paper, a list of all the existing systematic reviews of rehabilitation interest is reported.

## Materials and methods

The author systematically searched all the new reviews of rehabilitative interest from the 3rd 4th and 5th

Issues of 2010 of the Cochrane Library. We present the papers divided in subgroups on the base of the topic. We also continue the update of the list of reviews of interest for PRM specialists in Appendix 1 that was first published in 2007.[1] All new papers have been added to the list of Cochrane reviews of PRM interest, while the withdrawn reviews have been cancelled.

## Results

The number of included papers was 8, 7 of these were new reviews. Four new reviews deal with neurological rehabilitation, being performed by the Stroke group, 2 with musculoskeletal disorders, 1 with cardiac rehabilitation. Moreover, 1 review by the Back Group has been updated. All these are listed in the remaining of the paper.

The author will find the main results of each single review in the following paragraphs, being the reviews divided into "New" and "Updated", and further according to the topic and the Cochrane Group.

## New reviews

### *Neurological rehabilitation*

#### Cochrane Stroke Group

*Circuit class therapy for improving mobility after stroke*.-The author included six trials involving 292 participants.[2] Participants were long-term stroke survivors living in the community or receiving inpatient rehabilitation. All could walk 10 meters with or without assistance. Four studies measured walking capacity and three measured gait speed, demonstrating that Circuit class therapy (CCT) was superior to the comparison intervention (Six Minute Walk Test: mean difference (MD), fixed 76.57 meters, 95% confidence interval (CI) 38.44 to 114.70, P<0.0001; gait speed: MD, fixed 0.12 m/s, 95% CI 0.00 to 0.24, P=004). Two studies measured balance, showing a superior effect in favour of CCT (Step Test: MD, fixed 3.00 steps, 95% CI 0.08 to 5.91, P=0.04; activities-specific balance and confidence: MD, fixed 7.76, 95% CI 0.66 to 14.87, P=0.03). Studies also measured other balance items showing no difference in effect. Length of stay (two studies) showed a significant effect in favour of CCT (MD, fixed -19.73 days, 95% CI -35.43 to -4.04, P=0.01). Only two studies measured adverse events (falls during therapy): all were minor. CCT is safe and effective in improving mobility for people after moderate stroke and may reduce inpatient length of stay. Further research is required, investigating quality of life, participation and cost-benefits, that compares CCT to standard care and that also investigates the differential effects of stroke severity, latency and age.

*Interventions for sensory impairment in the upper limb after stroke*.-The authors included 13 studies, with a total 467 participants, testing a range of different interventions.[3] Outcome measures included 36 measures of sensory impairment and 13 measures of upper limb function. All but two studies had unclear or high risk of bias. While there is insufficient evidence to reach conclusions about the effects of interventions included in this review, three studies provided preliminary evidence for the effects of some specific interventions, including mirror therapy for improving detection of light touch, pressure and temperature pain; a thermal stimulation intervention for improving rate of recovery of sensation; and intermittent pneumatic compression intervention for improving tactile and kinesthetic sensation. We could not perform meta-analysis due to a high degree of clinical heterogeneity in both interventions and outcomes. Multiple interventions for upper limb sensory impairment after stroke are described but there is insufficient evidence to support or refute their effectiveness in improving sensory impairment, upper limb function, or participants' functional status and participation. There is a need for more well-designed, better reported studies of sensory rehabilitation.

*Music therapy for acquired brain injury*.-The authors included seven studies (184 participants).[4] The results suggest that rhythmic auditory stimulation (RAS) may be beneficial for improving gait parameters in stroke patients, including gait velocity, cadence, stride length and gait symmetry. These results were based on two studies that received a low risk of bias score. There were insufficient data to examine the effect of music therapy on other outcomes. RAS may be beneficial for gait improvement in people with stroke. These results are encouraging, but more RCTs are needed before recommendations can be made for clinical practice. More research is needed to examine the effects of music therapy on other outcomes in people with acquired brain injury.

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*Stroke liaison workers for stroke patients and carers: an individual patient data meta-analysis.*-The authors included 16 trials involving 4 759 participants.[5] Analysis did not show a significant overall difference for subjective health status (standardised mean difference [SMD] -0.03, 95% confidence interval [CI] -0.11 to 0.04, P=0.34) or extended activities of daily living (SMD 0.04, 95% CI -0.03 to 0.11, P=0.22). There was no overall significant effect for the outcome of carer subjective health status (SMD 0.04, 95% CI -0.05 to 0.14, P=0.37). Patients with mild to moderate disability (Barthel 15 to 19) had a significant reduction in dependence (odds ratio [OR] 0.62, 95% CI 0.44 to 0.87, P=0.006). This would equate to 10 fewer dependent patients (95% CI 17 fewer to 4 fewer) for every 100 patients seen by the stroke liaison worker. Similar results were seen for the outcome of death or dependence for the subgroup with Barthel 15 to 19 (OR 0.55, 95% CI 0.38 to 0.81, P=0.002). This risk difference equates to 11 fewer dead or dependent patients (95% CI 17 fewer to 4 fewer) for every 100 patients seen by the stroke liaison worker. There is no evidence for the effectiveness of this multifaceted intervention in improving outcomes for all groups of patients or carers. Patients with mild to moderate disability benefit from a Reduction in death and disability. Patients and carers do report improved satisfaction with some aspects of service provision.

## Cochrane Heart Group

*Promoting patient uptake and adherence in cardiac rehabilitation.*-Ten studies were identified, three of interventions to improve uptake of cardiac rehabilitation and seven of interventions to increase adherence.[6] Meta-analysis was not possible due to multiple sources of heterogeneity. All three interventions targeting uptake of cardiac rehabilitation were effective. Two of seven studies intended to increase adherence had a significant effect. Only one study reported the non-significant effects of the intervention on cardiovascular risk factors and no studies reported data on mortality, morbidities, costs or health care resource utilisation. There is some evidence to suggest that interventions to increase the uptake of cardiac rehabilitation can be effective. Few practice recommendations for increasing adherence to cardiac rehabilitation can be made at this time. Interventions targeting patient identified barriers may increase the likelihood of success. Further high quality research is needed.

## Cochrane Musculoskeletal Group

*Balance training (proprioceptive training) for patients with rheumatoid arthritis.*-The electronic search identified 864 studies.[7] From this search, 17 studies described general exercises in rheumatoid arthritis patients as the main topic. After analysing them, we observed that the main interventions were exercises to improve muscle strength, endurance, and dynamic exercises (swimming, walking, etc.). As we did not find any studies investigating the effects of balance training alone or in combination with other therapies in patients with rheumatoid arthritis, it was not possible to include any data regarding the chosen topic in this systematic review. There is no research available examining the efficacy of balance training alone in patients with rheumatoid arthritis. The effectiveness and safety of balance training to improve functional capacity of these patients remains unclear. We suggest that future research should give more importance to balance training by either increasing the number and duration of sessions or investigating its efficacy alone.

*Non-surgical interventions for paediatric pes planus.*-Three trials involving 305 children were included in this review.[8] Due to clinical heterogeneity, data were not pooled. All trials had potential for bias. Data from one trial (40 children with juvenile arthritis and foot pain) indicated that use of custom-made orthoses compared with supportive shoes alone resulted in significantly greater reduction in pain intensity (mean difference [MD] -1.5 points on a 10-point visual analogue scale [VAS], 95% CI -2.8 to -0.2; number need to treat to benefit NNTB] 3, 95% CI 2 to 23), and reduction in disability (measured using the disability subscale of the Foot Function Index on a 100 mm scale (MD -18.65 mm, 95% CI -34.42 to -2.68 mm). The second trial of seven to 11-year-old children with bilateral flat feet (N.=178) found no difference in the number of participants with foot pain between custom-made orthoses, prefabricated orthoses and the control group who received no treatment. A third trial of one to five year olds with bilateral flat feet (N.=129) did not report pain at baseline but reported the subjective impression of pain reduction after wearing shoes. No adverse effects were reported in the three trials.

The evidence from randomised controlled trials is currently too limited to draw definitive conclusions about the use of non-surgical interventions for pediatric pes planus. Future high quality trials are warranted in this field. Only limited interventions commonly used in practice have been studied and there is much debate over the treatment of symptomatic and asymptomatic pes planus.

## Updated reviews

*Musculoskeletal disorders*

COCHRANE BACK GROUP

*Behavioural treatment for chronic low-back pain*.-The authors included 30 randomised trials (3 438 participants) in this review, up 11 from the previous version.[9] Fourteen trials (47%) had low risk of bias. For most comparisons, there was only low or very low quality evidence to support the results. There was moderate quality evidence that: 1) operant therapy was more effective than waiting list (SMD -0.43; 95%CI -0.75 to -0.11) for short-term pain relief; 2) little or no difference exists between operant, cognitive, or combined behavioural therapy for short- to intermediate-term pain relief; 3) behavioural treatment was more effective than usual care for short-term pain relief (MD -5.18; 95%CI -9.79 to -0.57), but there were no differences in the intermediate- to long-term, or on functional status; 4) there was little or no difference between behavioural treatment and group exercise for pain relief or depressive symptoms over the intermediate- to long-term; 5) adding behavioural therapy to inpatient rehabilitation was no more effective than inpatient rehabilitation alone.

For patients with chronic low-back pain, there is moderate quality evidence that in the short-term, operant therapy is more effective than waiting list and behavioural therapy is more effective than usual care for pain relief, but no specific type of behavioural therapy is more effective than another. In the intermediate- to long-term, there is little or no difference between behavioural therapy and group exercises for pain or depressive symptoms. Further research is likely to have an important impact on our confidence in the estimates of effect and may change the estimates.

## Discussion

From the new synthesis of evidence coming from the included papers, it emerges in the field of neurological rehabilitation that the circuit class therapy is useful to improve mobility after stroke.[2] Moreover, in these patients, a rhythmic auditory stimulation (RAS) may be beneficial for improving gait parameters.[4] About multiple interventions for upper limb sensory impairment after stroke are described but there is insufficient evidence to support or refute their effectiveness in improving sensory impairment, upper limb function, or participants' functional status and participation.[3] About multifaceted rehabilitation there is no evidence for the effectiveness in improving outcomes for all groups of stroke patients or carers.[5] About the efficacy of interventions to improve patients adherence to cardiac rehabilitation, we must wait for further studies.[6] From the muskuloskeletal group, we must notice that we have no evidence today about the efficacy of balance training for Rheumatoid Arthritis [7] and for orthoses for pes planus.[8]

## Conclusions

The Cochrane Collaboration and his product, the Cochrane Library, are really relevant instruments to improve EBM in medical practice and thus also in the Rehabilitation Field. The present paper can help Rehabilitation Specialists to easily retrieve the conclusions of the most relevant and updated reviews in order to change their clinical practice in a more rapid and effective way.

## Appendix 1

*Acute respiratory infections group*

Chest physiotherapy for brochiolitis in children aged 0-24 months

*Airways group*

Educational interventions for asthma in children.[10]

Exercise and physical therapy for asthma (5 reviews).[11-15]

Oxygen therapy during exercise training in chronic obstructive pulmonary disease.[16]

Physical training for bronchiectasis.[17]

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Physical training for interstitial lung disease.[18]
Physical therapy and pulmonary rehabilitation for BPCO (2 reviews).[19, 20]

*Back group*

Antidepressants for non-specific low back pain.[21]
Back school, traction, exercise, massage, neuroreflexotherapy, spinal manipulation and heat or cold therapy for non specific low back pain (7 reviews).[22-28]
Behavioural treatment for chronic low-back pain.[9]
Braces for idiopathic scoliosis in adolescents.[29]
Electrotherapy for neck pain.[30]
Exercise, manipulation, massage, multidisciplinary rehabilitation and work conditioning for neck disorders (5 reviews).[31-35]
Individual patient education for low back pain.[36]
Insoles for prevention and treatment of back pain.[37]
Manipulation or mobilisation for neck pain.[38]
Mechanical traction for neck pain with or without radiculopathy.[39]
Multidisciplinary rehabilitation for sub acute low back pain (1 review).[40]
Neuroreflexotherapy for non-specific low-back pain.[25]
Patient education for low-back pain (1 review).[41]
Prolotherapy injections for chronic low-back pain.[42]
Rehabilitation after lumbar disk surgery (1 review).[43]

*Bone, joints and muscle trauma group:*

Antibiotics for treating chronic osteomyelitis in adults.[44]
Biospychological rehabilitation for repetitive upper limb injuries (1 review).[45]
Conservative interventions for treating middle third clavicle fractures in adolescents and adults.[46]
Exercise for anterior cruciate ligament injuries (1 review).[47]
Exercise for treating anterior cruciate ligament injuries in combination with collateral ligament and meniscal damage of the knee in adults.[48]
Exercise for improving balance in older people.[49]
Interventions for preventing falls in older people in nursing care facilities and hospitals.[50]
Interventions for preventing falls in older people living in the community.[51]
Multidisciplinary rehabilitation and mobilisation for hip fractures.[52]
Multidisciplinary rehabilitation programmes following joint replacement at the hip and knee in chronic arthropathy.[53]
Prosthesis after limb amputation.[54]
Rehabilitation after surgery for flexor tendon injuries in the hand.[55]
Rehabilitation for ankle fractures in adults.[56]
Rehabilitation for distal radial fractures.[57]
Rehabilitation interventions for improving physical and psychosocial functioning after hip fracture in older people.[58]
Stretching to prevent or reduce muscle soreness after exercise.[59]
Transcutaneous electrical nerve stimulation (TENS) for chronic low-back pain.[60]

*Breast cancer group*

Physical therapy for limphoedema (1 review).[61]
Exercise for women receiving adjuvant therapy (1 review).[62]

*Cystic fibrosis and genetic disorders group*

Chest physiotherapy and physical training for cystic fibrosis (4 reviews).[63-66]

*Dementia and cognitive impairment group*

Cognitive rehabilitation for Alzheimer disease (1 review).[67]
Light therapy, music therapy, reminiscence therapy, snoezelen, massage and touch, TENS, validation therapy for dementia (7 reviews).[68-74]
Physical activity and enhanced fitness to improve cognitive function in older people without known cognitive impairment.[75]
Physical activity programs for persons with dementia.[76]

Developmental, Psychosocial and Learning Problems Group

Intervention for childhood apraxia of speech.[9]
Intervention for dysarthria associated with acquired brain injury in children and adolescents.[77]
Personal assistance for adults (19-64) with physical impairments.[78]
Personal assistance for adults (19-64) with both physical and intellectual impairments.[79]
Personal assistance for children and adolescents (0-18) with both physical and intellectual impairments.[80]
Personal assistance for children and adolescents (0-18) with intellectual impairments.[81]

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Personal assistance for children and adolescents (0-18) with physical impairments.[82]

Personal assistance for adults (19-64) with both physical and intellectual impairments.[79]

*Ear, Nose and Throat Disorders Group*

Vestibular rehabilitation for unilateral peripheral vestibular dysfunction.[83]

*Eyes and vision group*

Orientation and modility training and reading aids for people with low vision (2 reviews).[84, 85]

*Heart group*

Exercise for coronary heart disease.[86]

Home-based versus centre-based cardiac rehabilitation.[87]

Promoting patient uptake and adherence in cardiac rehabilitation.[6]

*HIV/AIDS group*

Aerobic exercise and progressive resistive interventions (2 reviews).[88, 89]

Incontinence Group

Botulinum toxin injections for adults with overactive bladder syndrome.[90]

Pelvic floor muscle training for prevention and treatment of urinary and faecal incontinence in antenatal and postnatal women.[91]

Pelvic floor muscle training versus no treatment, or inactive control treatments, for urinary incontinence in women.[92]

*Injuries group*

Interventions for apathy after traumatic brain injury.[93]

Locomotor training for walking after spinal cord injury.[94]

Pharmacological interventions for spasticity following spinal cord injury.[95]

Sensory stimulation for brain injured individuals in coma or vegetative state.[96]

Spinal injuries centre for people with acute traumatic spinal cord injuries.[97]

Multi-disciplinary rehabilitation for acquired brain injury in adults of working age.[98]

Pharmacological treatment for agitation and aggression on people with acquired brain injuries.[99]

Workplace interventions for preventing work disability.[100]

Metabolic and endocrin disorder group

Exercise and Group based training for self-management strategies for type 2 diabetes mellitus (2 reviews).[101, 102]

Exercise for overweight or obesity.[103]

Menstrual Disorders and Subfertility Group

Exercise for vasomotor menopausal symptoms.[104]

Movement disorder group

Botulinum toxin type A and B for cervical dystonia (4 reviews).[105-108]

Botulinum toxin type A for lower and upper limb spasticity in cerebral palsy (2 reviews).[109, 110]

Bromocriptine versus levodopa in early Parkinson's disease.[111]

Occupational therapy for Parkinson's disease.[112]

Physiotherapy for Parkinson's disease (2 reviews).[113, 114]

Speech and language therapy for Parkinson's disease and cerebral palsy (3 reviews).[115-117]

Non-pharmacological therapies for dysphagia in Parkinson's disease.[118]

Pimozide for tics in Tourette's syndrome.[119]

Therapeutic interventions for disease progression in Huntington's disease.[120]

Therapeutic interventions for symptomatic treatment in Huntington's disease.[121]

Treadmill training for patients with Parkinson's disease.[122]

Multiple Sclerosis Group

Anti-spasticity agents for multiple sclerosis.[123]

Exercise therapy, Occupational therapy for multiple sclerosis (2 reviews).[124, 125]

Multidisciplinary rehabilitation for adults with multiple sclerosis.[126]

Oral versus Intravenous Steroids for Treatment of Relapses in Multiple Sclerosis.[127]

Treatment for ataxia in multiple sclerosis.[128]

Musculoskeletal Group

Alendronate for the primary and secondary prevention of osteoporotic fractures in postmenopausal women.[129]

Balance training (proprioceptive training) for patients with rheumatoid arthritis.[7]

Balneotherapy, Occupational therapy, Splints and Orthosis for rheumatoid arthritis (3 reviews).[130-132]

Balneotherapy for osteoarthritis.[133]

Bisphosphonate therapy for children and adolescents with secondary osteoporosis.[134]

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Braces and orthoses, Transcutaneous electrical nerve stimulation, Therapeutic ultrasound for treating osteoarthritis of the knee (3 reviews).[135-137]

Continuous passive motion following total knee arthroplasty.[138]

Corticosteroid injection for de Quervain's tenosynovitis.[139]

Custom-made foot orthoses for the treatment of foot pain.[140]

Deep transverse friction massage for treating tendinitis.[141]

Electrical stimulation, Low level laser therapy (Classes I, II and III), Thermotherapy, Therapeutic ultrasound for the treatment of rheumatoid arthritis (4 reviews).[142-145]

Electromagnetic fields, Thermotherapy for the treatment of osteoarthritis (2 reviews).[146, 147]

Exercise for acutely hospitalised older medical patients.[148]

Exercise for osteoarthritis of the hip or knee.[149]

Exercise for preventing and treating osteoporosis in postmenopausal women.[150]

Exercise for osteoarthritis of the hip.[151]

Exercise for treating fibromyalgia syndrome.[152]

Exercise therapy in juvenile idiopathic arthritis.[153]

Glucosamine therapy for treating osteoarthritis.[154]

Home versus center based physical activity programs in older adults.[155]

Intensity of exercise for the treatment of osteoarthritis.[156]

Multidisciplinary rehabilitation for fibromyalgia and musculoskeletal pain in working age adults.[157]

Non-surgical interventions for paediatric pes planus.[8]

Orthotic devices, Shock wave therapy for lateral elbow pain (2 review).[158, 159]

Patient education for adults with rheumatoid arthritis.[160]

Physiotherapy interventions for ankylosing spondylitis.[161]

Physiotherapy interventions for shoulder pain.[162]

Therapeutic ultrasound for treating patellofemoral pain syndrome.[163]

Transcutaneous electrostimulation for osteoarthritis of the knee.[164]

Topical glyceryl trinitrate for rotator cuff disease.[165]

Transcutaneous electrical nerve stimulation (TENS) for the treatment of rheumatoid arthritis in the hand.[166]

Neonatal group

Chest physiotherapy for preventing morbidity in babies being extubated from mechanical ventilation.[167]

Chest physiotherapy for reducing respiratory morbidity in infants requiring ventilatory support.[168]

Neuromuscular Disease Group

Acupuncture for Bell's palsy.[169]

Exercise for people with peripheral neuropathy.[170]

Physical therapy for Bell's palsy (idiopathic facial paralysis).[171]

Rehabilitation interventions for foot drop in neuromuscular disease.[172]

Strength training and aerobic exercise training for muscle disease.[173]

Therapeutic exercise for people with amyotrophic lateral sclerosis or motor neuron disease.[174]

Treatment for Charcot-Marie-Tooth disease.[175]

Treatment for idiopathic and hereditary neuralgic amyotrophy (brachial neuritis).[176]

Treatment for meralgia paraesthetica.[177]

Treatment for spasticity in amyotrophic lateral sclerosis/motor neuron disease.[178]

Treatment for swallowing difficulties (dysphagia) in chronic muscle disease.[179]

Pain, Palliative and Supportive Care Group

Antidepressants for neuropathic pain.[180]

Antipsychotics for acute and chronic pain in adults.[181]

Cyclobenzaprine for the treatment of myofascial pain in adults.[182]

Exercise for the management of cancer-related fatigue in adults.[183]

Music for pain relief.[184]

Non-invasive physical treatments for chronic/recurrent headache.[185]

Pregabalin for acute and chronic pain in adults.[186]

Psychological therapies for the management of chronic pain (excluding headache) in adults.[187]

Topical rubefacients for acute and chronic pain in adults.[188]

Touch therapies for pain relief in adults.[189]

Transcutaneous electrical nerve stimulation for acute pain.[190]

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Transcutaneous electrical nerve stimulation (TENS) for chronic pain.[191]

Peripheral Vascular Diseases Group

Exercise for intermittent claudication.[192]

Low molecular weight heparin for prevention of venous thromboembolism in patients with lower-leg immobilization.[193]

Pregnancy and Childbirth Group

Transcutaneous electrical nerve stimulation (TENS) for pain relief in labour.[194]

Stroke Group

Acanthopanax for acute ischaemic stroke.[195]

Acupuncture for stroke rehabilitation.[196]

Acupuncture for dysphagia in acute stroke.[197]

Circuit class therapy for improving mobility after stroke.[2]

Cognitive rehabilitation for attention deficits, memory deficits, spatial neglect following stroke (3 reviews).[198-200]

Electrical stimulation and Supportive devices for preventing and treating post-stroke shoulder pain and subluxation (2 reviews).[201, 202]

Electromechanical-assisted training for walking after stroke.[203]

Electromechanical and robot-assisted arm training for improving arm function and activities of daily living after stroke.[204]

Electrostimulation for promoting recovery of movement or functional ability after stroke.[205]

EMG biofeedback for the recovery of motor function after stroke.[206]

Force platform feedback for standing balance training after stroke.[207]

Information provision for stroke patients and their caregivers.[208]

Interventions for apraxia of speech following stroke.[209]

Interventions for dysphagia in acute stroke.[210]

Interventions for motor apraxia following stroke.[211]

Interventions for post-stroke fatigue.[212]

Interventions for sensory impairment in the upper limb after stroke.[3]

Stroke liaison workers for stroke patients and carers: an individual patient data meta-analysis.[5]

Mailuoning for acute ischemic stroke.[213]

Music therapy for acquired brain injury.[4]

Occupational therapy for patients with problems in activities of daily living after stroke.[214]

Organised inpatient (stroke unit) care for stroke.[215]

Overground physical therapy gait training for chronic stroke patients with mobility deficits.[216]

Physical fitness training for stroke patients.[217]

Physiotherapy treatment approaches for the recovery of postural control and lower limb function following stroke.[218]

Speech and language therapy for aphasia and dysarthria due to non-progressive brain damage (2 reviews).[219, 220]

Stroke liaison workers for stroke patients and carers: an individual patient data meta-analysis.[5]

Therapy-based rehabilitation services for stroke patients at home.[221]

Therapy-based rehabilitation services for patients living at home more than one year after stroke.[222]

Treadmill training and body weight support for walking after stroke.[223]

Wounds Group

Honey as a topical treatment for wounds.[224]

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