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EJPRM systematic continuous update on Cochrane reviews in rehabilitation: news from the 8th, 9th and 10th issues of 2010

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***Aim*. Since 2007 we have focused our attention to the best available clinical evidence 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 lists and presents all these reviews systematically. The aim of the present paper was to systematically review all the new rehabilitation papers published in the 8th, 9th and 10th 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 8th, 9th and 10th 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 four, all of these were new reviews. Two new reviews deal with neurological rehabilitation , one with musculoskeletal disorders and one with pain. No updated reviews were retrieved.**

***Conclusion*. The Cochrane Collaboration and 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.**

KEY WORDS: Rehabilitation - Physician's practice patterns - Rehabilitation centers.

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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 8th, 9th and 10th Issues of 2010. In 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 8th, 9th and 10th 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 re-

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views of PRM interest, while the withdrawn reviews have been cancelled.

Results

The number of included papers was four, all of these were new reviews. Two new reviews deal with neurological rehabilitation , one with musculoskeletal disorders and one with pain. No updated reviews were retrieved.

The reader will find the main results of each single review in the following paragraphs, being the reviews divided according to the topic and the Cochrane Group.

Pain treatment

Pain, Palliative and Supportive Care Group

Non-invasive brain stimulation techniques for chronic pain.—The authors included 33 trials in the review (involving 937 people) (19 rTMS, eight CES and six tDCS).[2] Only one study was judged as being at low risk of bias.

Studies of repetitive transcranial magnetic stimulation (TMS) involving 368 participants demonstrated significant heterogeneity. Pre-specified subgroup analyses suggest that low-frequency stimulation is ineffective. A short-term effect on pain of active high-frequency stimulation of the motor cortex in single-dose studies was suggested (standardised mean difference [SMD] -0.40, 95% confidence interval [CI] -0.26 to -0.54, P<0.00001). This equates to a 15% (95% CI 10% to 20%) reduction in pain which does not clearly exceed the pre-established criteria for a minimally clinically important difference (>15%).

For cranial electrotherapy stimulation (CES) (four studies, 133 participants) no statistically significant difference was found between active stimulation and sham. Analysis of transcranial direct current stimulation (tDCS) studies (five studies, 83 people) demonstrated significant heterogeneity and did not find a significant difference between active and sham stimulation. Pre-specified subgroup analysis of tDCS applied to the motor cortex suggested superiority of active stimulation over sham (SMD -0.59, 95% CI -1.10 to -0.08).

Non-invasive brain stimulation appears to be associated with minor and transient side effects.

Single doses of high-frequency rTMS of the motor cortex may have small short-term effects on chronic pain. The effects do not clearly exceed the predetermined threshold of minimal clinical significance. Low-frequency rTMS is not effective in the treatment of chronic pain. There is insufficient evidence from which to draw firm conclusions regarding the efficacy of CES or tDCS. The available evidence suggests that tDCS applied to the motor cortex may have short-term effects on chronic pain and that CES may be ineffective. There is a need for further, rigorously designed studies of all types of stimulation.

Musculoskeletal rehabilitation

Cochrane Musculoskeletal Group

Stretch for the treatment and prevention of contractures.—Thirty-five studies with 1 391 participants met the inclusion criteria.[3] No study performed stretch for more than seven months. In people with neurological conditions, there was moderate to high quality evidence to indicate that stretch does not have clinically important immediate (mean difference 3°; 95% CI 0 to 7), short-term (mean difference 1°; 95% CI 0 to 3) or long-term (mean difference 0°; 95% CI -2 to 2) effects on joint mobility. The results were similar for people with non-neurological conditions. For all conditions, there is little or no effect of stretch on pain, spasticity, activity limitation, participation restriction or quality of life.

Stretch does not have clinically important effects on joint mobility in people with, or at risk of, contractures if performed for less than seven months. The effects of stretch performed for periods longer than seven months have not been investigated.

Neurological rehabilitation

Cochrane Stroke Group

Occupational therapy for cognitive impairment in stroke patients.—We included one trial with 33 participants in this review.[4] We found no difference between groups for the two relevant outcomes that were measured: improvement in time judgement skills and improvement in basic ADLs on the Barthel Index.

The effectiveness of occupational therapy for cognitive impairment post-stroke remains unclear. The potential benefits of cognitive retraining delivered as part of occupational therapy on improving basic daily activity function or specific cognitive abilities,

or both, of people who have had a stroke cannot be supported or refuted by the evidence included in this review. More research is required.

NEUROMUSCULAR DISEASE GROUP

Multidisciplinary care for Guillain-Barré syndrome.—No randomised controlled trials or controlled clinical trials were identified.[5]

In the absence of randomised controlled trials or controlled clinical trials, the 'best' evidence to date comes from three 'very low quality' observational studies. These provide some support for improved disability in the short term (less than six months) with high intensity inpatient multidisciplinary rehabilitation; and for improved quality of life, as measured by a reduction in handicap (participation). These conclusions are tentative and the gap in current research should not be interpreted as proof that multidisciplinary care is ineffective. Further research is needed into appropriate study designs; outcome measurement; caregiver needs; and the evaluation of optimal settings, type, intensity or frequency and cost-effectiveness of multidisciplinary care in the Guillain-Barré syndrome population.

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.

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APPENDIX 1

Acute respiratory infections group
– Chest physiotherapy for brochiolitis in children aged 0-24 months

Airways group
– Educational interventions for asthma in children.[6]
– Exercise and physical therapy for asthma (5 reviews).[7-11]
– Oxygen therapy during exercise training in chronic obstructive pulmonary disease.[12]
– Physical training for bronchiectasis.[13]
– Physical training for interstitial lung disease.[14]
– Physical therapy and pulmonary rehabilitation for BPCO (2 reviews).[15, 16]

Back group
– Antidepressants for non-specific low back pain.[17]
– Back school, traction, exercise, massage, neuroreflexotherapy, spinal manipulation and heat or cold therapy for non specific low back pain (7 reviews).[18-24]
– Behavioural treatment for chronic low-back pain.[25]
– Braces for idiopathic scoliosis in adolescents.[26]
– Electrotherapy for neck pain.[27]
– Exercise, manipulation, massage, multidisciplinary rehabilitation and work conditioning for neck disorders (5 reviews).[28-32]
– Individual patient education for low back pain.[33]
– Insoles for prevention and treatment of back pain.[34]
– Manipulation or mobilisation for neck pain.[35]
– Mechanical traction for neck pain with or without radiculopathy.[36]

– Multidisciplinary rehabilitation for sub acute low back pain (1 review).[37]
– Neuroreflexotherapy for non-specific low-back pain.[21]
– Patient education for low-back pain (1 review).[38]
– Prolotherapy injections for chronic low-back pain.[39]
– Rehabilitation after lumbar disk surgery (1 review).[40]

Bone, joints and muscle trauma group
– Antibiotics for treating chronic osteomyelitis in adults.[41]
– Biospychological rehabilitation for repetitive upper limb injuries (1 review).[42]
– Conservative interventions for treating middle third clavicle fractures in adolescents and adults.[43]
– Exercise for anterior cruciate ligament injuries (1 review).[44]
– Exercise for treating anterior cruciate ligament injuries in combination with collateral ligament and meniscal damage of the knee in adults.[45]
– Exercise for improving balance in older people.[46]
– Interventions for preventing falls in older people in nursing care facilities and hospitals.[47]
– Interventions for preventing falls in older people living in the community.[48]
– Multidisciplinary rehabilitation and mobilisation for hip fractures.[49]
– Multidisciplinary rehabilitation programmes following joint replacement at the hip and knee in chronic arthropathy.[50]
– Prosthesis after limb amputation.[51]
– Rehabilitation after surgery for flexor tendon injuries in the hand.[52]
– Rehabilitation for ankle fractures in adults.[53]
– Rehabilitation for distal radial fractures.[54]
– Rehabilitation interventions for improving physical and psychosocial functioning after hip fracture in older people.[55]
– Stretching to prevent or reduce muscle soreness after exercise.[56]
– Transcutaneous electrical nerve stimulation (TENS) for chronic low-back pain.[57]

Breast cancer group
– Physical therapy for limphoedema (1 review).[58]
– Exercise for women receiving adjuvant therapy (1 review).[59]

Cystic fibrosis and genetic disorders group
– Chest physiotherapy and physical training for cystic fibrosis (4 reviews).[60-63]

Dementia and cognitive impairment group
– Cognitive rehabilitation for Alzheimer disease (1 review).[64]
– Light therapy, music therapy, reminiscence therapy, snoezelen, massage and touch, TENS, validation therapy for dementia (7 reviews).[65-71]
– Physical activity and enhanced fitness to improve cognitive function in older people without known cognitive impairment.[72]
– Physical activity programs for persons with dementia.[73]

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.[74]
– Personal assistance for adults (19-64) with physical impairments.[75]
– Personal assistance for adults (19-64) with both physical and intellectual impairments.[76]
– Personal assistance for children and adolescents 0-18 with both physical and intellectual impairments.[77]
– Personal assistance for children and adolescents (0-18) with intellectual impairments.[78]
– Personal assistance for children and adolescents (0-18) with physical impairments.[79]
– Personal assistance for adults 19-64 with both physical and intellectual impairments.[76]

Ear, Nose and Throat Disorders Group
– Vestibular rehabilitation for unilateral peripheral vestibular dysfunction.[80]

Eyes and vision group
– Orientation and modality training and reading aids for people with low vision (2 reviews).[81, 82]

Heart group
– Exercise for coronary heart disease.[83]
– Home-based versus centre-based cardiac rehabilitation.[84]
– Promoting patient uptake and adherence in cardiac rehabilitation.[85]

HIV/AIDS group
– Aerobic exercise and progressive resistive interventions (2 reviews).[86, 87]

Incontinence Group
– Botulinum toxin injections for adults with overactive bladder syndrome.[88]
– Pelvic floor muscle training for prevention and treatment of urinary and faecal incontinence in antenatal and postnatal women.[89]
– Pelvic floor muscle training versus no treatment, or inactive control treatments, for urinary incontinence in women.[90]

Injuries group
– Interventions for apathy after traumatic brain injury.[91]
– Locomotor training for walking after spinal cord injury.[92]
– Pharmacological interventions for spasticity following spinal cord injury.[93]
– Sensory stimulation for brain injured individuals in coma or vegetative state.[94]
– Spinal injuries centre for people with acute traumatic spinal cord injuries.[95]
– Multi-disciplinary rehabilitation for acquired brain injury in adults of working age.[96]
– Pharmacological treatment for agitation and aggression on people with acquired brain injuries.[97]
– Workplace interventions for preventing work disability.[98]

Metabolic and endocrin disorder group
– Exercise and Group based training for self-management strategies for type 2 diabetes mellitus (2 reviews).[99, 100]
– Exercise for overweight or obesity.[101]

Menstrual Disorders and Subfertility Group
– Exercise for vasomotor menopausal symptoms.[102]

Movement disorder group
– Botulinum toxin type A and B for cervical dystonia (4 reviews).[103-106]
– Botulinum toxin type A for lower and upper limb spasticity in cerebral palsy (2 reviews).[107, 108]

– Bromocriptine versus levodopa in early Parkinson's disease.[109]
– Occupational therapy for Parkinson's disease.[110]
– Physiotherapy for Parkinson's disease (2 reviews).[111, 112]
– Speech and language therapy for Parkinson's disease and cerebral palsy (3 reviews).[113-115]
– Non-pharmacological therapies for dysphagia in Parkinson's disease.[116]
– Pimozide for tics in Tourette's syndrome.[117]
– Therapeutic interventions for disease progression in Huntington's disease.[118]
– Therapeutic interventions for symptomatic treatment in Huntington's disease.[119]
– Treadmill training for patients with Parkinson's disease.[120]

Multiple Sclerosis Group
– Anti-spasticity agents for multiple sclerosis.[121]
– Exercise therapy, Occupational therapy for multiple sclerosis (2 reviews).[122, 123]
– Multidisciplinary rehabilitation for adults with multiple sclerosis.[124]
– Oral versus Intravenous Steroids for Treatment of Relapses in Multiple Sclerosis.[125]
– Treatment for ataxia in multiple sclerosis.[126]

Musculoskeletal Group
– Alendronate for the primary and secondary prevention of osteoporotic fractures in postmenopausal women.[127]
– Balance training (proprioceptive training) for patients with rheumatoid arthritis.[128]
– Balneotherapy, Occupational therapy, Splints and Orthosis for rheumatoid arthritis (3 reviews).[129-131]
– Balneotherapy for osteoarthritis.[132]
– Bisphosphonate therapy for children and adolescents with secondary osteoporosis.[133]
– Braces and orthoses, transcutaneous electrical nerve stimulation, therapeutic ultrasound for treating osteoarthritis of the knee (3 reviews).[134-136]
– Continuous passive motion following total knee arthroplasty.[137]
– Corticosteroid injection for de Quervain's tenosynovitis.[138]
– Custom-made foot orthoses for the treatment of foot pain.[139]
– Deep transverse friction massage for treating tendinitis.[140]
– Electrical stimulation, Low level laser therapy (Classes I, II and III), thermotherapy, therapeutic ultrasound for the treatment of rheumatoid arthritis (4 reviews).[141-144]
– Electromagnetic fields, thermotherapy for the treatment of osteoarthritis (2 reviews).[145, 146]
– Exercise for acutely hospitalised older medical patients.[147]
– Exercise for osteoarthritis of the hip or knee.148
– Exercise for preventing and treating osteoporosis in postmenopausal women.[149]
– Exercise for osteoarthritis of the hip.[150]
– Exercise for treating fibromyalgia syndrome.[151]
– Exercise therapy in juvenile idiopathic arthritis.[152]
– Glucosamine therapy for treating osteoarthritis.[153]
– Home versus center based physical activity programs in older adults.[154]
– Intensity of exercise for the treatment of osteoarthritis.[155]
– Multidisciplinary rehabilitation for fibromyalgia and musculoskeletal pain in working age adults.[156]
– Non-surgical interventions for paediatric *pes planus*.[157]
– 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]
– Stretch for the treatment and prevention of contractures.[3]
– 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]
– Multidisciplinary care for Guillain-Barré syndrome.[5]
– 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 brain stimulation techniques for chronic pain.[2]
– 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]

– 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.[198]
– Cognitive rehabilitation for attention deficits, memory deficits, spatial neglect following stroke (3 reviews).[199-201]
– Electrical stimulation and Supportive devices for preventing and treating post-stroke shoulder pain and subluxation (2 reviews).[202, 203]
– Electromechanical-assisted training for walking after stroke.[204]
– Electromechanical and robot-assisted arm training for improving arm function and activities of daily living after stroke.[205]
– Electrostimulation for promoting recovery of movement or functional ability after stroke.[206]
– EMG biofeedback for the recovery of motor function after stroke.[207]
– Force platform feedback for standing balance training after stroke.[208]
– Information provision for stroke patients and their caregivers.[209]
– Interventions for apraxia of speech following stroke.[210]
– Interventions for dysphagia in acute stroke.[211]
– Interventions for motor apraxia following stroke.[212]
– Interventions for post-stroke fatigue.[213]
– Interventions for sensory impairment in the upper limb after stroke.[214]
– Stroke liaison workers for stroke patients and carers: an individual patient data meta-analysis.[215]
– Mailuoning for acute ischaemic stroke.[216]
– Music therapy for acquired brain injury.[217]
– Occupational therapy for cognitive impairment in stroke patients.[4]
– Occupational therapy for patients with problems in activities of daily living after stroke.[218]
– Organised inpatient (stroke unit) care for stroke.[219]
– Overground physical therapy gait training for chronic stroke patients with mobility deficits.[220]
– Physical fitness training for stroke patients.[221]
– Physiotherapy treatment approaches for the recovery of postural control and lower limb function following stroke.[222]
– Speech and language therapy for aphasia and dysarthria due to non-progressive brain damage (2 reviews).[223, 224]
– Stroke liaison workers for stroke patients and carers: an individual patient data meta-analysis.[215]
– Therapy-based rehabilitation services for stroke patients at home.[225]
– Therapy-based rehabilitation services for patients living at home more than one year after stroke.[226]
– Treadmill training and body weight support for walking after stroke.[227]

Wounds Group

– Honey as a topical treatment for wounds.[228]