



EJPRM systematic continuous update on Cochrane reviews in rehabilitation: news from the 1st and 2nd 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 1st and 2nd 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 1st and 2nd 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 9, 5 of these were new reviews. One new review deal with neurological rehabilitation, 2 with musculoskeletal disorders, 1 with cardiac rehabilitation. Moreover, 5 reviews have been updated, 2 related to musculoskeletal disorders, 2 to neurological disorders, and 1 to pelvic floor rehabilitation.

Conclusion. The Cochrane Collaboration and its 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.

KEY WORDS: Nervous system disorders - Rehabilitation - Physician's practice patterns.

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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 1st and 2nd 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 1st and 2nd 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 I 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 9, 5 of these were new reviews. One new review deals with neurological rehabilitation, 2 with musculoskeletal disorders, 1 with cardiac rehabilitation. Moreover, 5 reviews have been updated, 2 related to musculoskeletal disorders, 2 to neurological disorders, and 1 to pelvic floor rehabilitation. 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 MOVEMENT DISORDERS GROUP

Treadmill training for patients with Parkinson's disease.—Eight trials (203 participants) were included in this review.² Treadmill training improved gait speed (SMD 0.50; 95% confidence interval [CI] 0.17 to 0.84; $P=0.003$; $I(2)=0\%$) (fixed-effect model), stride length (SMD 0.42; 95% CI 0.00 to 0.84; $P=0.05$; $I(2)=0\%$), walking distance (MD=358 m; 95% CI 289 to 426; $P<0.0001$; $I(2)=30\%$), but cadence did not improve (MD 1.06; 95% CI -4.32 to 6.44; $P=0.70$; $I(2)=0\%$) at the end of study. Treadmill training did not increase the risk of patients dropping out (RD -0.07; 95% CI -0.18 to 0.05; $P=0.26$; $I(2)=51\%$) (random-effects model). Adverse events were not reported.

Patients with Parkinson's disease who receive treadmill training are more likely to improve their impaired gait hypokinesia. However, the results must be interpreted with caution because there were variations between the trials in patient characteristics, the duration and amount of training, and types of treatment. Additionally, it is not known how long these improvements may last.

Musculoskeletal rehabilitation

COCHRANE BACK GROUP

Braces for idiopathic scoliosis in adolescents.—The authors included two studies.³ There was very low quality evidence from one prospective cohort study with 286 girls that a brace curbed curve progression at the end of growth (success rate 74% [95% CI: 52% to 84%]), better than observation (success rate 34% [95% CI:16% to 49%]) and electrical stimulation (success rate 33% [95% CI:12% to 60%]). There is low quality evidence from one RCT with 43 girls that a rigid brace is more successful than an elastic one (SpineCor) at curbing curve progression when measured in Cobb degrees, but there were no significant differences between the two groups in the subjective perception of daily difficulties associated with wearing the brace. There is very low quality evidence in favour of using braces, making generalization very difficult. Further research could change the actual results and our confidence in them; in the meantime, patients' choices should be informed by multidisciplinary discussion. Future research should focus on short and long-term patient-centred outcomes, in addition to measures such as Cobb angles. RCTs and prospective cohort studies should follow both the Scoliosis Research Society (SRS) and Society on Scoliosis Orthopaedic and Rehabilitation Treatment (SOSORT) criteria for bracing studies.

COCHRANE BONE, JOINT AND MUSCLE TRAUMA GROUP

Rehabilitation interventions for improving physical and psychosocial functioning after hip fracture in older people. Nine small heterogeneous trials (involving 1 400 participants) were included.⁴ The trials had differing interventions, including “usual care” comparators, providers, settings and outcome assessment. Although most trials appeared well conducted, poor reporting hindered assessment of their risk of bias. Three trials testing interventions (reorientation measures, intensive occupational therapy, cognitive behavioural therapy) delivered in inpatient settings found no significant differences in outcomes. Two trials tested specialist-nurse led care, which was predominantly post-discharge but included discharge planning in one trial: this trial found some benefits at three months but the other trial found no differences at 12 months. Coaching (edu-

cational and motivational interventions) was examined in two very different trials: one trial found no effect on function at six months; and the other showed coaching improved self-efficacy expectations at six months, although not when combined with exercise. Two trials testing interventions (home rehabilitation; group learning program) started several weeks after hip fracture found no significant differences in outcomes at 12 months.

Some outcomes may be amenable to psychosocial treatments; however, there is insufficient evidence to recommend practice changes. Further research on interventions described in this review is required, including attention to timing, duration, setting and administering discipline(s), as well as treatment across care settings. To facilitate future evaluations, a core outcome set, including patient-reported outcomes such as quality of life and compliance, should be established for hip fracture trials.

Cardiac rehabilitation

COCHRANE HEART GROUP

Home-based versus centre-based cardiac rehabilitation. Twelve studies (1 938 participants) met the inclusion criteria.⁵ The majority of studies recruited a lower risk patient following an acute myocardial infarction (MI) and revascularisation. There was no difference in outcomes of home- versus centre-based cardiac rehabilitation in mortality risk ratio (RR) was 1.31 (95% CI 0.65 to 2.66), cardiac events, exercise capacity standardised mean difference (SMD) -0.11 (95% CI -0.35 to 0.13), as well as in modifiable risk factors (systolic blood pressure; diastolic blood pressure; total cholesterol; HDL-cholesterol; LDL-cholesterol) or proportion of smokers at follow-up or health-related quality of life. There was no consistent difference in the healthcare costs of the two forms of cardiac rehabilitation.

Home- and centre-based cardiac rehabilitation appear to be equally effective in improving the clinical and health-related quality of life outcomes in acute MI and revascularisation patients. This finding, together with an absence of evidence of difference in healthcare costs between the two approaches, would support the extension of home-based cardiac rehabilitation programmes such as the Heart Manual to give patients a choice in line with their preferences, which may have an impact on uptake of cardiac rehabilitation in the individual case.

Updated reviews

Musculoskeletal disorders

COCHRANE BACK GROUP

Manipulation or mobilisation for neck pain.—We included 27 trials (1 522 participants).⁶ Cervical manipulation for subacute/chronic neck pain: moderate quality evidence suggested manipulation and mobilisation produced similar effects on pain, function and patient satisfaction at intermediate-term follow-up. Low quality evidence showed manipulation alone compared to a control may provide short-term relief following one to four sessions (SMD pooled -0.90 [95%CI: -1.78 to -0.02]) and that nine or 12 sessions were superior to three for pain and disability in cervicogenic headache. Optimal technique and dose need to be determined. Thoracic manipulation for acute/chronic neck pain: low quality evidence supported thoracic manipulation as an additional therapy for pain reduction (NNT 7; 46.6% treatment advantage) and increased function (NNT 5; 40.6% treatment advantage) in acute pain and favoured a single session of thoracic manipulation for immediate pain reduction compared to placebo for chronic neck pain (NNT 5, 29% treatment advantage). Mobilisation for subacute/chronic neck pain: in addition to the evidence noted above, low quality evidence for subacute and chronic neck pain indicated that: 1) a combination of Maitland mobilisation techniques was similar to acupuncture for immediate pain relief and increased function; 2) there was no difference between mobilisation and acupuncture as additional treatments for immediate pain relief and improved function; and 3) neural dynamic mobilisations may produce clinically important reduction of pain immediately post-treatment. Certain mobilisation techniques were superior.

Cervical manipulation and mobilisation produced similar changes. Either may provide immediate-or short-term change; no long-term data are available. Thoracic manipulation may improve pain and function. Optimal techniques and dose are unresolved. Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.

COCHRANE MUSCULOSKELETAL GROUP

Continuous passive motion following total knee arthroplasty in people with arthritis.—Twenty randomised controlled trials of 1 335 participants met the inclusion

criteria.⁷ There is high-quality evidence that continuous passive motion increases passive knee flexion range of motion (mean difference 2°, 95% CI 0 to 5) and active knee flexion range of motion (mean difference 3°, 95% CI 0 to 6). These effects are too small to be clinically worthwhile. There is low-quality evidence that continuous passive motion has no effect on length of hospital stay (mean difference -0.3 days; 95% CI -0.9 to 0.2) but reduces the need for manipulation under anaesthesia (relative risk 0.15; 95% CI 0.03 to 0.70).

The effects of continuous passive motion on knee range of motion are too small to justify its use. There is weak evidence that continuous passive motion reduces the subsequent need for manipulation under anaesthesia.

Neurological rehabilitation

COCHRANE MOVEMENT DISORDERS GROUP

Botulinum toxin A as an adjunct to treatment in the management of the upper limb in children with spastic cerebral palsy (UPDATE).—Ten trials met the inclusion criteria.⁸ PEDro quality ratings ranged from 6/10 to 10/10. Concentration of BoNT-A ranged from 50 U/1.0 mL to 200 U/1.0 mL saline with doses of 0.5 U to 16 U/kg body weight and total doses of 220 to 410 Units (Botox[R]). A combination of BoNT-A and occupational therapy is more effective than occupational therapy alone in reducing impairment, improving activity level outcomes and goal achievement, but not for improving quality of life or perceived self-competence. When compared with placebo or no treatment, there is moderate evidence that BoNT-A alone is not effective. Authors' conclusions: this systematic review found high level evidence supporting the use of BoNT-A as an adjunct to managing the upper limb in children with spastic CP. BoNT-A should not be used in isolation but should be accompanied by planned occupational therapy. Further research is essential to identify children most likely to respond to BoNT-A injections, monitor longitudinal outcomes, determine timing and effect of repeated injections and the most effective dosage, dilution and volume schedules. The most effective adjunct therapies including frequency and intensity of delivery also requires investigation.

COCHRANE NEUROMUSCULAR DISEASE GROUP

Strength training and aerobic exercise training for muscle disease.—We included three trials (121 par-

ticipants).⁹ The first compared the effect of strength training versus no training in 36 people with myotonic dystrophy. The second trial compared strength training versus no training, both combined with albuterol or placebo, in 65 people with facioscapulothoracic muscular dystrophy. The third trial compared combined strength training and aerobic exercise versus no training in 18 people with mitochondrial myopathy. In the myotonic dystrophy trial there were no significant differences between training and non-training groups for primary and secondary outcome measures. In the facioscapulothoracic muscular dystrophy trial only a +1.17 kg difference (95% CI 0.18 to 2.16) in dynamic strength of elbow flexors in favour of the training group reached statistical significance. In the mitochondrial myopathy trial there were no significant differences in dynamic strength measures between training and non-training groups. Exercise duration and distance cycled in a submaximal endurance test increased significantly in the training group compared to the control group.

In myotonic dystrophy and facioscapulothoracic muscular dystrophy, moderate-intensity strength training appears not to do harm but there is insufficient evidence to conclude that it offers benefit. In mitochondrial myopathy, aerobic exercise combined with strength training appears to be safe and may be effective in increasing submaximal endurance capacity. Limitations in the design of studies in other muscle diseases prevent more general conclusions in these disorders.

Pelvic floor rehabilitation

COCHRANE INCONTINENCE GROUP

Pelvic floor muscle training versus no treatment, or inactive control treatments, for urinary incontinence in women.—Fourteen trials involving 836 women (435 PFMT, 401 controls) met the inclusion criteria; twelve trials (672) contributed data to the analysis.¹⁰ Many studies were at moderate to high risk of bias, based on the trial reports. There was considerable variation in interventions used, study populations, and outcome measures. Women who did PFMT were more likely to report they were cured or improved than women who did not. Women who did PFMT also reported better continence specific quality of life than women who did not. PFMT women also experienced fewer incontinence episodes per day and less

leakage on short office-based pad test. Of the few adverse effects reported, none were serious. The trials in stress urinary incontinent women which suggested greater benefit recommended a longer training period than the one trial in women with detrusor overactivity (urge) incontinence.

The review provides support for the widespread recommendation that PFMT be included in first-line conservative management programmes for women with stress, urge, or mixed, urinary incontinence. Statistical heterogeneity reflecting variation in incontinence type, training, and outcome measurement made interpretation difficult. The treatment effect seems greater in women with stress urinary incontinence alone, who participate in a supervised PFMT programme for at least three months, but these and other uncertainties require testing in further trials.

Discussion

From the new synthesis of evidence coming from the included papers, it emerges in the field of neurological rehabilitation that treadmill can be helpful for improving gait in Parkinson's Disease.² Concerning musculoskeletal problems, there is some evidence in favour of the use of Braces, both rigid and soft, to prevent scoliosis evolution, being the rigid ones more effective than the soft.³

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APPENDIX 1

Acute respiratory infections group

Chest physiotherapy for bronchiolitis in children aged 0-24 months

Airways group

Educational interventions for asthma in children.¹¹
Exercise and physical therapy for asthma (5 reviews).¹²⁻¹⁶

Oxygen therapy during exercise training in chronic obstructive pulmonary disease.¹⁷

Physical training for bronchiectasis.¹⁸

Physical training for interstitial lung disease.¹⁹

Physical therapy and pulmonary rehabilitation for BPCO (2 reviews).^{20, 21}

Back group

Antidepressants for non-specific low back pain.²²

Back school, traction, exercise, massage, neuroreflexotherapy, spinal manipulation and heat or cold therapy for non specific low back pain (7 reviews).²³⁻²⁹

Bed rest for acute low back pain (1 review).³⁰

Behavioural treatment for chronic low-back pain.³¹

Braces for idiopathic scoliosis in adolescents.³

Electrotherapy for neck pain.³²

Exercise, manipulation, massage, multidisciplinary rehabilitation and work conditioning for neck disorders (5 reviews).³³⁻³⁷

Individual patient education for low back pain.³⁸

Insoles for prevention and treatment of back pain.³⁹

Manipulation or mobilisation for neck pain.⁶

Mechanical traction for neck pain with or without radiculopathy.⁴⁰

Multidisciplinary rehabilitation for sub acute low back pain (1 review).⁴¹

Neuroreflexotherapy for non-specific low-back pain.²⁶

Patient education for low-back pain (1 review).⁴²

Prolotherapy injections for chronic low-back pain.⁴³

Rehabilitation after lumbar disk surgery (1 review).⁴⁴

Bone, joints and muscle trauma group

Antibiotics for treating chronic osteomyelitis in adults.⁴⁵

Biospsychological rehabilitation for repetitive upper limb injuries (1 review).⁴⁶

Conservative interventions for treating middle third clavicle fractures in adolescents and adults.⁴⁷

Exercise for anterior cruciate ligament injuries (1 review).⁴⁸

Exercise for treating anterior cruciate ligament injuries in combination with collateral ligament and meniscal damage of the knee in adults.⁴⁹

Exercise for improving balance in older people.⁵⁰

Interventions for preventing falls in older people in nursing care facilities and hospitals.⁵¹

Interventions for preventing falls in older people living in the community.⁵²

Multidisciplinary rehabilitation and mobilisation for hip fractures.⁵³

Multidisciplinary rehabilitation programmes following joint replacement at the hip and knee in chronic arthropathy.⁵⁴

Prosthesis after limb amputation.⁵⁵

Rehabilitation after surgery for flexor tendon injuries in the hand.⁵⁶

Rehabilitation for ankle fractures in adults.⁵⁷

Rehabilitation for distal radial fractures.⁵⁸

Rehabilitation interventions for improving physical and psychosocial functioning after hip fracture in older people.⁴

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

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 mobility 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.⁵

HIV/AIDS group

Aerobic exercise and progressive resistive interventions (2 reviews).^{87, 88}

Incontinence group

Botulinum toxin injections for adults with overactive bladder syndrome.⁸⁹

Pelvic floor muscle training for prevention and treatment of urinary and faecal incontinence in antenatal and postnatal women.⁹⁰

Pelvic floor muscle training *versus* no treatment, or inactive control treatments, for urinary incontinence in women.¹⁰

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).^{8, 107}

Bromocriptine *versus* levodopa in early Parkinson's disease.¹⁰⁸

Occupational therapy for Parkinson's disease.¹⁰⁹

Physiotherapy for Parkinson's disease (2 reviews).^{110, 111}

Speech and language therapy for Parkinson's disease and cerebral palsy (3 reviews).¹¹²⁻¹¹⁴

Non-pharmacological therapies for dysphagia in Parkinson's disease.¹¹⁵

- Pimozide for tics in Tourette's syndrome.¹¹⁶
- Therapeutic interventions for disease progression in Huntington's disease.¹¹⁷
- Therapeutic interventions for symptomatic treatment in Huntington's disease.¹¹⁸
- Treadmill training for patients with Parkinson's disease.²

Multiple sclerosis group

- Anti-spasticity agents for multiple sclerosis.¹¹⁹
- Exercise therapy, occupational therapy for multiple sclerosis (2 reviews).^{120, 121}
- Multidisciplinary rehabilitation for adults with multiple sclerosis.¹²²
- oral *versus* intravenous steroids for treatment of relapses in multiple sclerosis.¹²³
- Treatment for ataxia in multiple sclerosis.¹²⁴

Musculoskeletal group

- Alendronate for the primary and secondary prevention of osteoporotic fractures in postmenopausal women.¹²⁵
- Balneotherapy, occupational therapy, splints and orthosis for rheumatoid arthritis (3 reviews).¹²⁶⁻¹²⁸
- Balneotherapy for osteoarthritis.¹²⁹
- Bisphosphonate therapy for children and adolescents with secondary osteoporosis.¹³⁰
- Braces and orthoses, transcutaneous electrical nerve stimulation, therapeutic ultrasound for treating osteoarthritis of the knee (3 reviews).¹³¹⁻¹³³
- Continuous passive motion following total knee arthroplasty.¹³⁴
- Corticosteroid injection for de Quervain's tenosynovitis.¹³⁵
- Custom-made foot orthoses for the treatment of foot pain.¹³⁶
- Deep transverse friction massage for treating tendinitis.¹³⁷
- Electrical stimulation, low level laser therapy (Classes I, II and III), thermotherapy, therapeutic ultrasound for the treatment of rheumatoid arthritis (4 reviews).¹³⁸⁻¹⁴¹
- Electromagnetic fields, thermotherapy for the treatment of osteoarthritis (2 reviews).^{142, 143}
- Exercise for acutely hospitalised older medical patients.¹⁴⁴
- Exercise for osteoarthritis of the hip or knee.¹⁴⁵
- Exercise for preventing and treating osteoporosis in postmenopausal women.¹⁴⁶

- Exercise for osteoarthritis of the hip.¹⁴⁷
- Exercise for treating fibromyalgia syndrome.¹⁴⁸
- Exercise therapy in juvenile idiopathic arthritis.¹⁴⁹
- Glucosamine therapy for treating osteoarthritis.¹⁵⁰
- Home versus center based physical activity programs in older adults.¹⁵¹
- Intensity of exercise for the treatment of osteoarthritis.¹⁵²
- Multidisciplinary rehabilitation for fibromyalgia and musculoskeletal pain in working age adults.¹⁵³
- Orthotic devices, Shock wave therapy for lateral elbow pain (2 review).^{154, 155}
- Patient education for adults with rheumatoid arthritis.¹⁵⁶
- Physiotherapy interventions for ankylosing spondylitis.¹⁵⁷ Physiotherapy interventions for shoulder pain.¹⁵⁸
- Therapeutic ultrasound for treating patellofemoral pain syndrome.¹⁵⁹
- Transcutaneous electrostimulation for osteoarthritis of the knee.¹⁶⁰
- Topical glyceryl trinitrate for rotator cuff disease.¹⁶¹
- Transcutaneous electrical nerve stimulation (TENS) for the treatment of rheumatoid arthritis in the hand.¹⁶²

Neonatal group

- Chest physiotherapy for preventing morbidity in babies being extubated from mechanical ventilation.¹⁶³
- Chest physiotherapy for reducing respiratory morbidity in infants requiring ventilatory support.¹⁶⁴

Neuromuscular disease group

- Acupuncture for Bell's palsy.¹⁶⁵
- Exercise for people with peripheral neuropathy.¹⁶⁶
- Physical therapy for Bell's palsy (idiopathic facial paralysis).¹⁶⁷
- Rehabilitation interventions for foot drop in neuromuscular disease.¹⁶⁸
- Strength training and aerobic exercise training for muscle disease.⁹
- Therapeutic exercise for people with amyotrophic lateral sclerosis or motor neuron disease.¹⁶⁹
- Treatment for Charcot-Marie-Tooth disease.¹⁷⁰
- Treatment for idiopathic and hereditary neuralgic amyotrophy (brachial neuritis).¹⁷¹
- Treatment for meralgia paraesthetica.¹⁷²
- Treatment for spasticity in amyotrophic lateral sclerosis/motor neuron disease.¹⁷³
- Treatment for swallowing difficulties (dysphagia) in chronic muscle disease.¹⁷⁴

Pain, palliative and supportive care group

- Antidepressants for neuropathic pain.¹⁷⁵
- Antipsychotics for acute and chronic pain in adults.¹⁷⁶
- Cyclobenzaprine for the treatment of myofascial pain in adults.¹⁷⁷
- Exercise for the management of cancer-related fatigue in adults.¹⁷⁸
- Music for pain relief.¹⁷⁹ Non-invasive physical treatments for chronic/recurrent headache.¹⁸⁰
- Pregabalin for acute and chronic pain in adults.¹⁸¹
- Psychological therapies for the management of chronic pain (excluding headache) in adults.¹⁸²
- Topical rubefaciants for acute and chronic pain in adults.¹⁸³
- Touch therapies for pain relief in adults.¹⁸⁴
- Transcutaneous electrical nerve stimulation for acute pain.¹⁸⁵
- Transcutaneous electrical nerve stimulation (TENS) for chronic pain.¹⁸⁶

Peripheral vascular diseases group

- Exercise for intermittent claudication.¹⁸⁷
- Low molecular weight heparin for prevention of venous thromboembolism in patients with lower-leg immobilization.¹⁸⁸

Pregnancy and childbirth group

- Transcutaneous electrical nerve stimulation (TENS) for pain relief in labour.¹⁸⁹

Stroke group

- Acanthopanax for acute ischaemic stroke.¹⁹⁰
- Acupuncture for stroke rehabilitation.¹⁹¹
- Acupuncture for dysphagia in acute stroke.¹⁹²
- Cognitive rehabilitation for attention deficits, memory deficits, spatial neglect following stroke (3 reviews).¹⁹³⁻¹⁹⁵
- Electrical stimulation and supportive devices for

preventing and treating post-stroke shoulder pain and subluxation (2 reviews)^{196, 197}

Electromechanical-assisted training for walking after stroke¹⁹⁸

Electromechanical and robot-assisted arm training for improving arm function and activities of daily living after stroke¹⁹⁹

Electrostimulation for promoting recovery of movement or functional ability after stroke²⁰⁰

EMG biofeedback for the recovery of motor function after stroke²⁰¹

Force platform feedback for standing balance training after stroke²⁰²

Information provision for stroke patients and their caregivers²⁰³

Interventions for apraxia of speech following stroke²⁰⁴

Interventions for dysphagia in acute stroke²⁰⁵

Interventions for motor apraxia following stroke²⁰⁶

Interventions for post-stroke fatigue²⁰⁷

Mailuoning for acute ischaemic stroke²⁰⁸

Occupational therapy for patients with problems in activities of daily living after stroke²⁰⁹

Organised inpatient (stroke unit) care for stroke²¹⁰

Overground physical therapy gait training for chronic stroke patients with mobility deficits²¹¹

Physical fitness training for stroke patients²¹²

Physiotherapy treatment approaches for the recovery of postural control and lower limb function following stroke²¹³

Speech and language therapy for aphasia and dysarthria due to non-progressive brain damage (2 reviews).^{214, 215}

Therapy-based rehabilitation services for stroke patients at home.²¹⁶

Therapy-based rehabilitation services for patients living at home more than one year after stroke.²¹⁷

Treadmill training and body weight support for walking after stroke.²¹⁸

Wounds group

- Honey as a topical treatment for wounds.²¹⁹