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EJPRM systematic continuous update on Cochrane reviews in rehabilitation: news from the 3rd Issue 2009

F. ZAINA, S. NEGRINI

Aim. **Since 2007 we have been focusing our attention to EJPRM as the best available clinical evidence as offered by the Cochrane Collaboration. Due to the absence of a specific Rehabilitation Group (only a Field does exist), some reviews in the field of PRM are not easy to find. Consequently, the EJPRM lists and presents all these reviews systematically. The aim of the present paper is to systematically review all the new papers in the field of rehabilitation published in the 3rd Issue of 2009 from the Cochrane Library in order to provide physicians a summary of the best updated evidence.**

Methods. **The authors systematically searched all the new papers of on rehabilitation from the 3rd Issue 2009 of the Cochrane Library. The retrieved papers have been divided in subgroups on the base of theirs topic and the Cochrane Groups.**

Results. **The number of included papers was 18, 14 of them being new reviews, 7 new reviews dealing with neurological rehabilitation, 4 dealing with musculoskeletal disorders, 3 dealing with pain management. In addition, 4 reviews have been updated, 1 in the field of musculoskeletal disorders, 2 on neuromuscular disorders, and 1 on elderly rehabilitation. The Cochrane Collaboration and the Cochrane Library are two important instruments to improve evidence-based medicine (EBM) in medical practice and in the field of rehabilitation.**

Conclusion. **The present paper can help rehabilitation specialists to retrieve the findings of the most relevant and updated reviews in order to better their clinical practice.**

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

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Corresponding author: F. Zaina, ISICO (Italian Scientific Spine Institute), Via Roberto Bellarmino 13/1, Milan, Italy.
E-mail: fabio.zaina@isico.it

ISICO (Italian Scientific Spine Institute), Milan, Italy

Knowledge and papers about rehabilitation topics have been growing during the last few years. Some results are discordant, others are based on a small population, thus limiting the validity of the findings. The best way to deal with these problems and to synthesize the results driving to clinical indications is to order systematically reviews according to their topic. This is the main aim of the Cochrane Collaboration, so that today the Cochrane reviews are considered the most reliable synthesis instruments. In order to provide our readers with 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 Issue of 2009. At the end of the paper, a list of all the existing systematic reviews of rehabilitation interested is reported.

Materials and methods

The author systematically searched all the new reviews of rehabilitative interest from the 3rd Issue 2009 of the Cochrane Library. We present the papers divided in subgroups on the base of the topic. From

this review we also started a continuous update of the list of reviews of interest for PRM specialists in Appendix 1, which 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 18, 14 of these were new reviews. 7 new review dealing with neurological rehabilitation, 4 dealing with musculoskeletal disorders, 3 dealing with pain management.

Moreover, 4 reviews have been updated, 1 in the field of musculoskeletal disorders, 2 on neuromuscular disorders, and 1 on elderly rehabilitation. All these are listed in the other papers.

New reviews

Musculoskeletal rehabilitation

Cochrane Bone, Joint and Muscle Trauma Group

Antibiotics for treating chronic osteomyelitis in aults.—iEight small trials were included (257 participants in total, with data available from 228).[2] Study quality was often inadequate: in particular, concealment of allocation was not confirmed and there was an absence of blinding of outcome assessment. The antibiotic regimens, duration of treatment and follow-up varied between trials. Five trials compared oral *versus* parenteral antibiotics. There was no statistically significant difference between the two groups in the remission rate 12 or more months after treatment (risk ratio 0.94, 95% confidence interval [CI] 0.78 to 1.13; 3 trials). Antibiotic treatment for osteomyelitis was associated with moderate or severe adverse events in 4.8% of patients allocated oral antibiotics and 15.5% patients allocated parenteral antibiotics (risk ratio: 0.40, 95% confidence interval 0.13 to 1.22; 4 trials). Single trials with very few participants found no statistical significant differences for remission or adverse events for the following three comparisons: parenteral plus oral versus parenteral only administration; two oral antibiotic regimens; and two parenteral antibiotic regimens. No trials compared different durations of antibiotic treatment for chronic osteomyelitis, or adjusted the remission rate for bacteria species or severity of disease.

Limited evidence suggests that the method of antibiotic administration (oral *versus* parenteral) does not affect the rate of disease remission if the bacteria are sensitive to the antibiotic used. However, this and the lack of statistically significant differences in adverse effects need confirmation. No or insufficient evidence exists for other aspects of antibiotic therapy for chronic osteomyelitis.

Cochrane Musculoskeletal Group

Corticosteroid injection for de Quervain's tenosynovitis.—One controlled clinical trial of 18 participants (all pregnant or lactating women) comparing one steroid injection with methylprednisolone and bupivacaine to splinting with a thumb spica was found.[3] All patients in the steroid injection group (9/9) achieved complete relief of pain whereas none of the patients in the thumb spica group (0/9) had complete relief of pain, 1 to 6 days after intervention (number needed to treat to benefit [NNTB]=1.95% CI 0.8 to 1.2). No side effects or local complications of steroid injection were noted.

The efficacy of corticosteroid injections for de Quervain's tenosynovitis has been studied in only one small controlled clinical trial, which found steroid injections to be superior to thumb spica splinting. However, the applicability of these findings to daily clinical practice is limited, as they are based on only one trial with a small number of included participants, the methodological quality was poor and only pregnant and lactating women participated in the study. No adverse effects were observed.

Exercise for osteoarthritis of the hip.—Combining the results of the 5 included randomized controlled trials (RCTs) demonstrated a small treatment effect for pain, but no benefit in terms of improved self-reported physical function.[4]

Only one of these five RCTs exclusively recruited people with symptomatic hip OA.

The limited number and small sample size of the included RCTs restricts the confidence that can be attributed to these results. Adequately powered RCTs evaluating exercise programs specifically designed for people with symptomatic hip OA need to be conducted.

Topical glyceryl trinitrate for rotator cuff disease.-

Three small studies, one at moderate risk of bias and two at high risk of bias, were included.[5] Meta-analysis was precluded due to different interventions and outcome measures. Study participants also had differing durations of symptoms and data for pain and function could only be extracted from one study. One placebo-controlled trial (20 participants) tested 5 mg glyceryl trinitrate patches, used daily for three days, among participants with 'acute supraspinatus tendinitis' of less than seven days duration. Treatment resulted in reduced pain intensity (adjusted MD -3.50, 95% CI -3.96 to -3.04). Function was not measured. One trial (53 participants) compared one quarter of a 5 mg glyceryl trinitrate patch used daily for up to 24 weeks combined with rehabilitation to placebo patches and rehabilitation among participants with 'supraspinatus tendinopathy' for longer than six months. A third trial (48 participants) tested 5 mg glyceryl trinitrate patches, used daily for three days, compared to corticosteroid injection among participants with 'rotator cuff tendinitis' of less than six-weeks duration. Fifteen out of 24 participants in the glyceryl trinitrate treatment reported headache (RR 0.11, 95% CI 0.01 to 1.96).

There is some evidence from one study at high risk of bias that topical glyceryl trinitrate is more effective than placebo for rotator cuff disease among patients with acute symptoms (< seven-days duration), but there is insufficient evidence to be certain about their longer-term effects. Headache was a common side effect in one trial and any benefits of treatment need to be balanced against the risk of headache. Further high quality research is needed to determine the effectiveness and safety of this new therapy.

Neurological rehabilitation

Cochrane Movement Disorders Group

Therapeutic interventions for disease progression in Huntington's disease.—Eight trials were included involving a total of 1366 HD patients.[6] The duration of the studies ranged between 30 and 144 weeks (median: 52 weeks). The following interventions were selected: vitamin E, Idebenone, Baclofen, Lamotrigine, creatine, coenzyme Q10 + Remacemide, ethyl-eicosapentanoic acid and Riluzole. No trials produced positive results for the selected efficacy outcome measures. A descriptive summary of the trials is provided. The selected interventions were found to be generally safe and well tolerated.

Only pharmacological interventions were included and none proved to be effective as a disease-modifying therapy for HD. Further trials with greater methodological quality should be conducted using more sensitive biological markers. Pre-symptomatic mutation carriers should be included in future studies.

Therapeutic interventions for symptomatic treatment in Huntington's disease.—Twenty-two trials (1 254 participants) were included. Nine trials had a cross-over design and 13 were conducted in parallel.[7] Study duration ranged from 2 to 80 weeks. Various pharmacological interventions were studied, mostly, they were anti-dopaminergic drugs (N=5), glutamate receptor antagonists (N=5) and energy metabolites (N=5). Only tetrabenazine showed a clear efficacy for the control of chorea. The remaining pharmacological interventions revealed no clear effectiveness.

No intervention proved to have a consistent symptomatic control in HD. Tetrabenazine is the anti-choreic drug with the best quality data available. Other symptomatic areas should be explored by well-designed randomised placebo-controlled studies.

Cochrane Multiple Sclerosis Group

Oral versus Intravenous Steroids for Treatment of Relapses in Multiple Sclerosis.—Four eligible studies (167 patients) were identified.[8] Only one outcome, the proportion of patients with EDSS improvement at 4 weeks, was common to three trials. Otherwise outcomes were too heterogeneous to pool. Only one trial employed an equivalence design, but all reported no statistically significant difference in outcomes between groups. Namely, there was no significant difference in the degree of recovery 4 weeks following treatment. No difference was found in subsequent relapse rate, disability, hospitalization, ambulation, bioavailability, or in magnetic resonance imaging (MRI). Due to methodological limitations, heterogeneous treatment regimens and limited data, formal conclusions about equivalence of oral and intravenous steroids cannot be made. Oral Megadose Corticosteroid Therapy of Acute Exacerbations of Multiple Sclerosis (OMEGA) trial, designed to address such limitations, is currently underway.

The trials reviewed support the hypothesis that no significant differences in clinical, radiological or pharmacological outcomes oral and intravenous steroids

for MS relapses exist. However, with the small number of patients and methodological limitations, conclusions of equivalence are premature.

Cochrane Neuromuscular Disease Group

Treatment for idiopathic and hereditary neuralgic amyotrophy (brachial neuritis).—No randomized or quasi-randomized trials were identified.[9] In 30 articles anecdotal evidence was found on treatment for neuralgic amyotrophy. Only three of these articles contained more than 10 treated cases, with one providing sufficient details to calculate the primary and secondary outcome measures for this review.

At this moment there is no evidence from randomized trials on any form of treatment for neuralgic amyotrophy. Evidence from one open-label retrospective series suggests that oral prednisone given in the first month after onset can shorten the duration of the initial pain and leads to earlier recovery in some patients. RCTs are needed to establish the efficacy of treatment with corticosteroids or other immune-modulating therapies.

Cochrane Stroke Group

Acanthopanax for acute ischaemic stroke.—Thirteen trials (962 participants) were included; the period of follow up in all included trials ranged from 10 to 30 days.[10] None of the trials reported the pre-specified primary outcome death or dependency during the follow-up period. The outcome measure in all included trials was the improvement of neurological deficit after treatment; acanthopanax was associated with a significant increase in the number of participants whose neurological impairment improved (risk ratio [RR] 1.22, 95% CI 1.15 to 1.29). Two trials reported adverse events; 5 trials reported no adverse events.

The risk of bias in all the included trials was high, and hence the data were not adequate to draw reliable conclusions about the efficacy of acanthopanax in acute stroke. Much larger trials of greater methodological quality are needed.

Interventions for post-stroke fatigue.—Three trials were identified.[11] One randomized 83 patients with emotional disturbance after stroke to fluoxetine or placebo. After correcting for differences in fatigue severity at baseline, there was no significant difference in fatigue between groups at follow up. The second trial randomized 31 women with subarachnoid hemorrhage to tirilazad or placebo, of whom 18 were available for follow-up. There was no difference in fatigue between the two groups. The third trial investigated a chronic disease self-management programme in 1 150 patients with chronic diseases, of whom 125 had had a stroke. There was no difference in fatigue at follow up between the treatment and control in the subgroup with stroke.

There is insufficient evidence available to guide the management of fatigue after stroke. Further trials are required.

Overground physical therapy gait training for chronic stroke patients with mobility deficits.—Nine studies involving 499 participants were included.[12] We found no evidence for a benefit on the primary variable, post-test gait function, based on three studies with 269 participants. Uni-dimensional performance variables did show significant effects post-test. Gait speed increased by 0.07 metres per second (95% CI 0.05 to 0.10) based on seven studies with 396 participants, timed up-and-go (TUG) test improved by 1.81 seconds (95% CI -2.29 to -1.33), and six-minute-walk test (6MWT) increased by 26.06 metres (95% CI 7.14 to 44.97) based on four studies with 181 participants. We found no significant differences in deaths/disabilities or in adverse effects, based on published reports or personal communication from all of the included studies.

It was found insufficient evidence to determine if overground physical therapy gait training benefits gait function in patients with chronic stroke, though limited evidence suggests small benefits for uni-dimensional variables such as gait speed or 6MWT. These findings must be replicated by large, high quality studies using varied outcome measures.

Pain

Cochrane Pain, Palliative and Supportive Care Group

Cyclobenzaprine for the treatment of myofascial pain in adults.—Two studies with a total of 79 participants were identified.[13] One study, with 41 participants, compared cyclobenzaprine with clonazepam and with placebo. Participants taking cyclobenzaprine had some improvement of pain intensity compared to those on clonazepam, mean difference (MD) -0.25 (95% CI, -0.41 to -0.09; P value 0.002) and placebo, MD -0.25 (95% CI, 0.41 to -0.09; P value 0.002). The other study, with 38 participants, compared cyclobenzaprine with lidocaine infiltration. Thirty days after treatment there were statistically non-significant differ-

ences between comparison groups, favoring lidocaine infiltration, for the mean for global pain, MD 0.90 (95% CI -0.35 to 2.15, P value 0.16), and for the mean for pain at digital compression, MD 0.60 (95% CI -0.55 to 1.75, P value 0.30). There were no life-threatening adverse events associated with the medications.

There was insufficient evidence to support the use of cyclobenzaprine in the treatment of MP. Only two small studies in which a total of 35 participants were given cyclobenzaprine, and it was not possible to estimate risks for benefits or harms. Further high quality RCTs of cyclobenzaprine for treating MP need to be conducted before firm conclusions on its effectiveness and safety can be made. Experts in this area should elect cut-off points for participants to identify whether a patient has achieved a clinically relevant reduction of pain (primary outcome), so that their results can be combined easily into future versions of this review.

Pregabalin for acute and chronic pain in adults.— There was no clear evidence of beneficial effects of pregabalin in established acute postoperative pain.[14] No studies evaluated pregabalin in chronic nociceptive pain, like arthritis.

Pregabalin at doses of 300 mg, 450 mg, and 600 mg daily was effective in patients with postherpetic neuralgia, painful diabetic neuropathy, central neuropathic pain, and fibromyalgia (19 studies, 7003 participants). Pregabalin at 150 mg daily was generally ineffective. Efficacy was demonstrated for dichotomous outcomes equating to moderate or substantial pain relief, alongside lower rates for lack of efficacy discontinuations with increasing dose. The best (lowest) NNT for each condition for at least 50% pain relief over baseline (substantial benefit) for 600 mg pregabalin daily compared with placebo were 3.9 (95% confidence interval 3.1 to 5.1) for postherpetic neuralgia, 5.0 (4.0 to 6.6) for painful diabetic neuropathy, 5.6 (3.5 to 14) for central neuropathic pain, and 11 (7.1 to 21) for fibromyalgia.

With 600 mg pregabalin daily somnolence typically occurred in 15% to 25% and dizziness occurred in 27% to 46%. Treatment was discontinued due to adverse events in 18% to 28%. The proportion of participants reporting at least one adverse event was not affected by dose, nor was the number with a serious adverse event, which was not more than with placebo.

Higher rates of substantial benefit were found in postherpetic neuralgia and painful diabetic neuropathy than in central neuropathic pain and fibromyalgia. For moderate and substantial benefit on any outcome NNTs for the former were generally six and below for 300 mg and 600 mg daily; for fibromyalgia NNTs were much higher, and generally seven and above.

Pregabalin has proven efficacy in neuropathic pain conditions and fibromyalgia. A minority of patients will have substantial benefit with pregabalin, and more will have moderate benefit. Many will have no or trivial benefit, or will discontinue because of adverse events. Individualisation of treatment is needed to maximise pain relief and minimise adverse events. There is no evidence to support the use of pregabalin in acute pain scenarios.

Topical rubefacients for acute and chronic pain in adults.—Six placebo and one active controlled studies (560 and 137 participants) in acute pain, and 7 placebo and 2 active controlled studies (489 and 90 participants) in chronic pain were included.[15] All used topical salicylates. The evidence in acute conditions was not robust; using only better quality, valid studies, there was no difference between topical rubefacient and topical control, though overall, including lower quality studies, the NNT for clinical success compared with placebo was 3.2 (95% CI: 2.4 to 4.9). In chronic conditions the NNT was 6.2 (95% CI: 4.0 to 13) compared with topical placebo. Adverse events and withdrawals occurred more often with rubefacients than placebo, but analyses were sensitive to inclusion of individual studies, so not robust. There were insufficient data to draw conclusions against active controls.

The evidence does not support the use of topical rubefacients containing salicylates for acute injuries, and suggests that in chronic conditions their efficacy compares poorly with topical non-steroidal antiinflammatory drugs (NSAIDs). Topical salicylates seem to be relatively well tolerated in the short-term, based on limited data. There is no evidence at all for topical rubefacients with other components.

Updated reviews

Elder rehabilitation

COCHRANE BONE, JOINT AND MUSCLE TRAUMA GROUP

Progressive resistance strength training for improving physical function in older adults.—One hundred and twenty one trials with 6700 participants were included.[16] In most trials, PRT was performed two to

three times per week and at a high intensity. PRT resulted in a small but significant improvement in physical ability (33 trials, 2 172 participants; SMD 0.14, 95% CI 0.05 to 0.22). Functional limitation measures also showed improvements: e.g. there was a modest improvement in gait speed (24 trials, 1179 participants, MD 0.08 m/s, 95% CI 0.04 to 0.12); and a moderate to large effect for getting out of a chair (11 trials, 384 participants, SMD -0.94, 95% CI -1.49 to -0.38). PRT had a large positive effect on muscle strength (73 trials, 3059 participants, SMD 0.84, 95% CI 0.67 to 1.00). Participants with osteoarthritis reported a reduction in pain following PRT(6 trials, 503 participants, SMD -0.30, 95% CI -0.48 to -0.13). There was no evidence from 10 other trials (587 participants) that PRT had an effect on bodily pain. Adverse events were poorly recorded but adverse events related to musculoskeletal complaints, such as joint pain and muscle soreness, were reported in many of the studies that prospectively defined and monitored these events. Serious adverse events were rare, and no serious events were reported to be directly related to the exercise programme.

This review provides evidence that PRT is an effective intervention for improving physical functioning in older people, including improving strength and the performance of some simple and complex activities. However, some caution is needed with transferring these exercises for use with clinical populations because adverse events are not adequately reported.

Musculoskeletal disorders

Cochrane Back Group

Antidepressants for non-specific low back pain.—Ten trials that compared antidepressants with placebo were included in this review.[17] The pooled analyses showed no difference in pain relief (6 trials [one trial with two treatment arms and a second trial with 3 treatment arms]; standardized mean difference [SMD] -0.04 [95% CI -0.25 to 0.17]) or depression (two trials; SMD 0.06 [95% CI -0.29 to 0.40]) between antidepressant and placebo treatments. The qualitative analyses found conflicting evidence on the effect of antidepressants on pain intensity in chronic low-back pain, and no clear evidence that antidepressants reduce depression in chronic low-back pain patients. Two pooled analyses showed no difference in pain relief between different types of antidepressants and placebo. Our findings were not altered by the sensitivity analyses, which varied the risk of bias allowed for inclusion in the meta-analyses to allow data from additional trials to be examined.

There is no clear evidence that antidepressants are more effective than placebo in the management of patients with chronic low-back pain. These findings do not imply that severely depressed patients with back pain should not be treated with antidepressants; furthermore, there is evidence for their use in other forms of chronic pain.

Neurological rehabilitation

Cochrane Injuries Group

Multi-disciplinary rehabilitation for acquired brain injury in adults of working age.—The authors identified 11 trials of good methodological quality and five of lower quality.[18] Within the subgroup of predominantly mild brain injury, 'strong evidence' suggested that most patients made a good recovery with provision of appropriate information, without additional specific intervention. For moderate to severe injury, there was 'strong evidence' of benefit from formal intervention. For patients with moderate to severe acquired brain injury already in rehabilitation, there was strong evidence that more intensive programmes are associated with earlier functional gains, and 'moderate evidence' that continued outpatient therapy could help to sustain gains made in early post-acute rehabilitation. There was 'limited evidence' that specialist in-patient rehabilitation and specialist multidisciplinary community rehabilitation may provide additional functional gains, but the studies serve to highlight the particular practical and ethical restraints on randomisation of severely affected individuals for whom there are no realistic alternatives to specialist intervention.

Problems following acquired brain injury vary. Consequently, different interventions and combinations of interventions are required to suit the needs of patients with different problems. Patients presenting acutely to hospital with moderate to severe brain injury should be routinely followed up to assess their needs for rehabilitation. Intensive intervention appears to lead to earlier gains. The balance between intensity and cost-effectiveness has yet to be determined. Patients discharged from in-patient rehabilitation should have access to out-patient or community-based services appropriate to their needs. Those with milder brain injury benefit from follow up and appropriate

information and advice. Not all questions in rehabilitation can be addressed by randomised controlled trials or other experimental approaches. Some questions include which treatments work best for which patients over the long term, and which models of service represent value for money in the context of lifelong care. In future, such questions will need to be set alongside practice-based evidence gathered from large systematic, longitudinal cohort studies conducted in the context of routine clinical practice.

COCHRANE NEUROMUSCULAR DISEASE GROUP

Rehabilitation interventions for foot drop in neuromuscular disease.—Early surgery did not significantly affect walking speed in a trial including 20 children with Duchenne muscular dystrophy.[19] Both groups deteriorated during the 12 months follow-up. After one year, the mean difference (MD) of the 28 feet walking time was 0.00 seconds (95% CI -0.83 to 0.83) and the MD of the 150 feet walking time was -2.88 seconds, favouring the control group (95% CI -8.18 to 2.42). Night splinting of the ankle did not significantly affect muscle force or range of movement about the ankle in a trial of 26 participants with Charcot-Marie-Tooth disease. Improvements were observed in both the splinting and control groups. In a trial of 26 participants with Charcot-Marie-Tooth disease and 28 participants with myotonic dystrophy, 24 weeks of strength training significantly improved six-metre timed walk in the Charcot-Marie-Tooth group compared to the control group (MD 0.70 seconds, favouring strength training, 95% CI 0.23 to 1.17), but not in the myotonic dystrophy group (MD -0.20 seconds, favouring the control group, 95% CI -0.79 to 0.39). No significant differences were observed for the 50 metre timed walk in the Charcot-Marie-Tooth disease group (MD 1.90 seconds, favouring the training group, 95% CI -0.29 to 4.09) or the myotonic dystrophy group (MD -0.80 seconds, favouring the control group, 95% CI -5.29 to 3.69). In a trial of 65 participants with facioscapulohumeral muscular dystrophy, 26 weeks of strength training did not significantly affect ankle strength. After one year, the mean difference in maximum voluntary isometric contraction was -0.43 kg, favouring the control group (95%CI -2.49 to 1.63) and the mean difference in dynamic strength was 0.44 kg, favouring the training group (95%CI -0.89 to 1.77).

Only one study, involving people with Charcot-Marie-Tooth disease, demonstrated a statistically significant positive effect of strength training. No effect of strength training was found in people with either myotonic dystrophy or facioscapulohumeral muscular dystrophy. Surgery had no significant effect in children with Duchenne muscular dystrophy and night splinting of the ankle had no significant effect in people with Charcot-Marie-Tooth disease. More evidence generated by methodologically sound trials is required.

Discussion

From the musculoskeletal group, that included 3 reviews, we had some indications of efficacy of topical glyceryl trinitrate for rotator cuff disease,[5] a weak evidence of efficacy of corticosteroid injection for de Quervain's tenosynovitis [3] and a weak evidence about the pain relief efficacy for exercise osteoarthritis of the hip without improvement of disability.[4]

Two reviews dealt with the Huntington disease, but none o the studied drugs reached significant results.[6, 7]

Stroke is a main topic in the rehabilitation field. Three systematic reviews in the 3rd Issue of 2009 of the Cochrane Library dealt with this, both regarding its acute phase and the outcome phase.[10-12] Despite this, evidence regarding the interventions investigated is still weak.

Among updated review, there weren't any change for the review about antidepressants for non-specific low back pain.[17] Exercise proved to be effective in improving foot drop in Charcot-Marie-Tooth Disease [19] and for improving physical functioning in older people, including improving strength and the performance of some simple and complex activities.[16]

Conclusions

The Cochrane Collaboration and the Cochrane Library are two important 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 findings of the most relevant and updated reviews in order to change their clinical practice in a more rapid and effective way (Appendix I).

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APPENDIX 1

Acute respiratory infections group:

Chest physiotherapy for brochiolitis in children aged 0-24 months

Airways group:

Exercise and physical therapy for asthma (5 reviews) [20-24]

Physical training for bronchiectasis [25]

Physical training for interstitial lung disease [26]

Physical therapy and pulmonary rehabilitation for BPCO (2 reviews) [27, 28]

Educational interventions for asthma in children [29]

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) [30-36]

Bed rest for acute low back pain (1 review) [37]

Behavioural treatment and TENS for chronic low back pain (2 reviews) [38, 39]

Exercise, manipulation, massage, multidisciplinary rehabilitation and work conditioning for neck disorders (5 reviews) [40-44]

Individual patient education for low back pain [45]

Insoles for prevention and treatment of back pain [46]

Mechanical traction for neck pain with or without radiculopathy [47]

Multidisciplinary rehabilitation for sub acute low back pain (1 review) [48]

Patient education for low-back pain (1 review) [49]

Rehabilitation after lumbar disk surgery (1 review) [50]

Bone, joints and muscle trauma group:

Antibiotics for treating chronic osteomyelitis in adults [2]

Biospychological rehabilitation for repetitive upper limb injuries (1 review) [51]

Conservative interventions for treating middle third clavicle fractures in adolescents and adults [52]

Exercise for anterior cruciate ligament injuries (1 review) [53]

Exercise for treating anterior cruciate ligament injuries in combination with collateral ligament and meniscal damage of the knee in adults [54]
Exercise for improving balance in older people [55]
Interventions for preventing falls in older people living in the community [56]
Multidisciplinary rehabilitation and mobilisation for hip fractures (2 reviews) [57, 58]
Multidisciplinary rehabilitation programmes following joint replacement at the hip and knee in chronic arthropathy [59]
Prosthesis after limb amputation (1 review) [60]
Rehabilitation after surgery for flexor tendon injuries in the hand (1 review) [61]
Rehabilitation for ankle fractures in adults [62]
Rehabilitation for distal radial fractures (1 review) [63]
Stretching to prevent or reduce muscle soreness after exercise [64]

Breast cancer group:
Physical therapy for limphoedema (1 review) [65]
exercise for women receiving adjuvant therapy (1 review) [66]

Cystic fibrosis and genetic disorders group:
Chest physiotherapy and physical training for cystic fibrosis (4 reviews) [67-70]

Dementia and cognitive impairment group:
Cognitive rehabilitation for Alzheimer disease (1 review) [71]
Light therapy, music therapy, reminiscence therapy, snoezelen, massage and touch,TENS, validation therapy for dementia (7 reviews) [72-78]
Physical activity and enhanced fitness to improve cognitive function in older people without known cognitive impairment [79]
Physical activity programs for persons with dementia [80]

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 [81]
Personal assistance for adults (19-64) with physical impairments [82]
Personal assistance for adults (19-64) with both physical and intellectual impairments [83]
Personal assistance for children and adolescents (0-18) with both physical and intellectual impairments [84]
Personal assistance for children and adolescents (0-18) with intellectual impairments [85]
Personal assistance for children and adolescents (0-18) with physical impairments [86]
Personal assistance for adults (19-64) with both physical and intellectual impairments [83]

Ear, Nose and Throat Disorders Group:
Vestibular rehabilitation for unilateral peripheral vestibular dysfunction [87]

Eyes and vision group:
Orientation and modility training and reading aids for people with low vision (2 reviews) [88, 89]

Heart group:
Exercise for coronary heart disease (1 review) [90]

HIV/AIDS group:
Aerobic exercise and progressive resistive interventions (2 reviews) [91, 92]

Incontinence Group.
Pelvic floor muscle training for prevention and treatment of urinary and faecal incontinence in antenatal and postnatal women [93]
Botulinum toxin injections for adults with overactive bladder syndrome [94]

Injuries group:
Interventions for apathy after traumatic brain injury [95]
Locomotor training for walking after spinal cord injury [96]
Pharmacological interventions for spasticity following spinal cord injury [97]
Sensory stimulation for brain injured individuals in coma or vegetative state [98]
Spinal injuries centre for people with acute traumatic spinal cord injuries [99]
Multi-disciplinary rehabilitation for acquired brain injury in adults of working age [18]
Pharmacological treatment for agitation and aggression on people with acquired brain injuries [100]
Workplace interventions for preventing work disability [101]

Metabolic and endocrin disorder group
Exercise and Group based training for self-management strategies for type 2 diabetes mellitus (2 reviews) [102, 103]
Exercise for overweight or obesity [104]

Menstrual Disorders and Subfertility Group
Exercise for vasomotor menopausal symptoms [105]

Movement disorder group
Botulinum toxin type A and B for cervical dystonia (4 reviews) [106-109]
Botulinum toxin type A for lower and upper limb spasticity in cerebral palsy (2 reviews) [110, 111]
Bromocriptine versus levodopa in early Parkinson's disease [112]
Occupational therapy for Parkinson's disease [113]
Physiotherapy for Parkinson's disease (2 reviews) [114, 115]
Speech and language therapy for Parkinson's disease and cerebral palsy (3 reviews) (116-118)

Non-pharmacological therapies for dysphagia in Parkinson's disease [119]
Pimozide for tics in Tourette's syndrome [120]
Therapeutic interventions for disease progression in Huntington's disease [6]
Therapeutic interventions for symptomatic treatment in Huntington's disease [7]

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 [8]
Treatment for ataxia in multiple sclerosis [125]

Musculoskeletal Group
Alendronate for the primary and secondary prevention of osteoporotic fractures in postmenopausal women [126]
Balneotherapy, Occupational therapy, Splints and Orthosis for rheumatoid arthritis (3 reviews) [127-129]
Balneotherapy for osteoarthritis [130]
Bisphosphonate therapy for children and adolescents with secondary osteoporosis [131]
Braces and orthoses, Transcutaneous electrical nerve stimulation, Therapeutic ultrasound for treating osteoarthritis of the knee (3 reviews) [132-134]
Continuous passive motion following total knee arthroplasty [135]
Corticosteroid injection for de Quervain's tenosynovitis [3]
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 [138-141] (4 reviews)
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 [4]
Exercise for treating fibromyalgia syndrome [147]
Exercise therapy in juvenile idiopathic arthritis [148]
Home versus center based physical activity programs in older adults [149]
Intensity of exercise for the treatment of osteoarthritis [150]
Multidisciplinary rehabilitation for fibromyalgia and musculoskeletal pain in working age adults [151]
Orthotic devices, Shock wave therapy for lateral elbow pain (2 review) [152, 153]
Patient education for adults with rheumatoid arthritis [154]
Physiotherapy interventions for ankylosing spondylitis [155]
Physiotherapy interventions for shoulder pain [156]
Therapeutic ultrasound for treating patellofemoral pain syndrome [157]
Transcutaneous electrical nerve stimulation (TENS) for the treatment of rheumatoid arthritis in the hand [158]

Neonatal group
Chest physiotherapy for preventing morbidity in babies being extubated from mechanical ventilation [159]
Chest physiotherapy for reducing respiratory morbidity in infants requiring ventilatory support [160]

Neuromuscular Disease Group
Acupuncture for Bell's palsy [161]
Exercise for people with peripheral neuropathy [162]
Physical therapy for Bell´s palsy (idiopathic facial paralysis) [163]
Rehabilitation interventions for foot drop in neuromuscular disease [164]
Strength training and aerobic exercise training for muscle disease [165]
Therapeutic exercise for people with amyotrophic lateral sclerosis or motor neuron disease [166]
Treatment for Charcot-Marie-Tooth disease [167]
Treatment for idiopathic and hereditary neuralgic amyotrophy (brachial neuritis) [9]
Treatment for meralgia paraesthetica [168]
Treatment for spasticity in amyotrophic lateral sclerosis/ motor neuron disease [169]
Treatment for swallowing difficulties (dysphagia) in chronic muscle disease [170]

Pain, Palliative and Supportive Care Group
Antidepressants for neuropathic pain [171]
Antipsychotics for acute and chronic pain in adults [172]
Cyclobenzaprine for the treatment of myofascial pain in adults [13]
Exercise for the management of cancer-related fatigue in adults [173]
Music for pain relief [174]
Non-invasive physical treatments for chronic/recurrent headache [175]
Pregabalin for acute and chronic pain in adults [14]
Psychological therapies for the management of chronic pain (excluding headache) in adults [176]
Topical rubefacients for acute and chronic pain in adults [15]
Touch therapies for pain relief in adults [177]
Transcutaneous electrical nerve stimulation for acute pain [178]

Transcutaneous electrical nerve stimulation (TENS) for chronic pain [179]

Peripheral Vascular Diseases Group

Exercise for intermittent claudication [180]

Low molecular weight heparin for prevention of venous thromboembolism in patients with lower-leg immobilization [181]

Pregnancy and Childbirth Group

Transcutaneous electrical nerve stimulation (TENS) for pain relief in labour [182]

Stroke Group

Acanthopanax for acute ischaemic stroke [10]

Acupuncture for stroke rehabilitation [183]

Acupuncture for dysphagia in acute stroke [184]

Cognitive rehabilitation for attention deficits, memory deficits, spatial neglect following stroke (3 reviews) [185-187]

Electrical stimulation and Supportive devices for preventing and treating post-stroke shoulder pain and subluxation (2 reviews) [188, 189]

Electromechanical-assisted training for walking after stroke [190]

Electromechanical and robot-assisted arm training for improving arm function and activities of daily living after stroke [191]

Electrostimulation for promoting recovery of movement or functional ability after stroke [192]

EMG biofeedback for the recovery of motor function after stroke [193]

Force platform feedback for standing balance training after stroke [194]

Information provision for stroke patients and their caregivers [195]

Interventions for apraxia of speech following stroke [196]

Interventions for dysphagia in acute stroke [197]

Interventions for motor apraxia following stroke [198]

Interventions for post-stroke fatigue [11]

Mailuoning for acute ischaemic stroke [199]

Occupational therapy for patients with problems in activities of daily living after stroke [200]

Organised inpatient (stroke unit) care for stroke [201]

Overground physical therapy gait training for chronic stroke patients with mobility deficits [12]

Physical fitness training for stroke patients [202]

Physiotherapy treatment approaches for the recovery of postural control and lower limb function following stroke [203]

Speech and language therapy for aphasia and dysarthria due to non-progressive brain damage (2 reviews) [204, 205]

Therapy-based rehabilitation services for stroke patients at home [206]

Therapy-based rehabilitation services for patients living at home more than one year after stroke. [207]

Treadmill training and body weight support for walking after stroke [208]

Wounds Group

Honey as a topical treatment for wounds [209]