EJPRM systematic continuous update on Cochrane reviews in rehabilitation: news from December 2011 to February 2012

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Aim. 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, being these considered the most reliable instruments of synthesis, reliable because based on a strict methodology. Moreover, according to the aim of the Cochrane Collaboration, in order to diffuse sound data, we invited Cochrane authors to republish their articles in the EJPRM. The aim of the present paper is to systematically review all the new rehabilitation papers published from December 2011 up to February 2012 from the Cochrane Library in order to provide to physicians involved in the field a summary of the best evidence nowadays available.

Methods. The authors systematically searched all the new papers of rehabilitation interest from the 5th of December 2011 to the 27th of February 2012 in 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 5, 4 new reviews and 2 updates reviews. A synthesis of abstracts is presented.

Conclusion. The field of rehabilitation, being cross-sectional to the whole Medicine, can be of interest for many specialty. It was documented by the large number of Cochrane Group publishing reviews of Rehabilitative interest. Reviewing periodically the Cochrane reviews is a good way to remain up to date and to find solid bases for everyday clinical practice.

Key words: Rehabilitation - Cochrane review - Cochrane library.

As far as the number of scientific paper increases it’s possible to find some discrepancies among different studies. Moreover, an overview that synthesizes the available knowledge, by solving the discrepancies from different papers can help the physicians to apply the best evidence based clinical practice.

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, being these considered the most reliable instruments of synthesis, reliable because based on a strict methodology. Moreover, according to the aim of the Cochrane Collaboration, in order to diffuse sound data, we invited Cochrane authors to republish their articles in the EJPRM.

In the present article readers can find a list of papers of rehabilitative interest systematically researched and reviewed published from the 5th of December 2011 to the 27th of February 2012 in the Cochrane Library.

Materials and methods

The authors systematically searched all the new papers of rehabilitative interest from the 5th of December 2011 to the 27th of February 2012 in the Cochrane Library. The retrieved papers have been...
then divided in subgroups on the base of the topic and the Cochrane Groups. We use to make a list of all the existing systematic reviews of rehabilitation interest and update it regularly after its last publication. 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 5, 3 new reviews and 2 updated review. 3 reviews deals with neurological rehabilitation (2 new and one updated) while 2 with pelvic floor rehabilitation (one new and one is updated).

The reviews have been divided according to the topic and the Cochrane Group, and the main findings and authors conclusion are reported directly from the abstract of the original articles.

New reviews

Neurological rehabilitation

Cochrane developmental, psychosocial and learning problems group

Treadmill interventions with partial body weight support in children under six years of age at risk of neuromotor delay 9 — The authors included five studies, which reported on treadmill intervention in 139 children. Of the 139 children, 73 were allocated to treadmill intervention groups, with the other children serving as controls. The studies varied in the type of population studied (children with Down syndrome; cerebral palsy or who were at risk for neuromotor delay); the type of comparison (for example, treadmill versus no intervention, high intensity treadmill versus low intensity); the time of evaluation (during the intervention or at various intervals after intervention), and the parameters assessed. Due to the diversity of the studies, we were only able to use data from three studies in meta-analyses and these were limited to two outcomes: age of onset of independent walking and gross motor function. Evidence suggested that treadmill intervention could lead to earlier onset of independent walking when compared to no treadmill intervention (two studies; effect estimate -1.47; 95% confidence interval (CI): -2.97, 0.03), though these trials studied two different populations and children with Down syndrome seemed to benefit while it was not clear if this was the case for children at high risk of neuromotor disabilities. Another two studies, both in children with Down syndrome, compared different types of treadmill intervention: one compared treadmill intervention with and without orthotics, while the other compared high versus low intensity treadmill intervention. Both were inconclusive regarding the impact of these different protocols on the age at which children started to walk. There is insufficient evidence to determine whether treadmill intervention improves gross motor function (two studies; effect estimate 0.88; 95% CI: -4.54, 6.30). In the one study evaluating treadmill with and without orthotics, results suggested that adding orthotics might hinder gross motor progress (effect estimate -8.40; 95% CI: -14.55, -2.25). One study of children with Down syndrome measured the age of onset of assisted walking and reported those receiving the treadmill intervention were able to walk with assistance earlier than those who did not receive the intervention (effect estimate -7.40; 95% CI: -13.54, -12.60). Another study comparing high and low intensity treadmill was unable to conclude whether one was more effective than the other in helping children achieve supported walking at an earlier age (effect estimate -1.86; 95% CI: -4.09, 0.37). One study of children at high risk of neuromotor disabilities evaluated step quality and found a statistically significant benefit from treadmill intervention compared to no treadmill intervention (effect estimate at 16 months of age: -15.61; 95% CI: -23.96, -7.27), but was not able to conclude whether there was a beneficial effect from treadmill training on step frequency at the same age (effect estimate at 16 months of age: 4.36; 95% CI: -2.63, 11.35). Step frequency was also evaluated in children with Down syndrome in another study and those who received high intensity rather than low intensity treadmill training showed an increased number of alternating steps (effect estimate 11.00; 95% CI: 6.03, 15.97). Our other primary outcome, falls and injuries due to falls, was not measured in any of the included studies.

The current review provided only limited evidence of the efficacy of treadmill intervention in children up to six years of age. Few studies have assessed treadmill interventions in young children...
using an appropriate control group (which would be usual treatment or no treatment). The available evidence indicates that treadmill intervention may accelerate the development of independent walking in children with Down syndrome. Further research is needed to confirm this and also address whether intensive treadmill intervention can accelerate walking onset in young children with cerebral palsy and high risk infants, and whether treadmill intervention has a general effect on gross motor development in the various subgroups of young children at risk for developmental delay.9

**Cochrane Neuromuscular Disease Group**

**Physical training for McArdle disease.**—There were no randomised or quasi-randomised controlled trials of aerobic training in people with McArdle disease. However, three open studies using small numbers of participants provided some evidence that aerobic training improves fitness without adverse events in people with McArdle disease.10

Evidence from non-randomised studies using small numbers of patients suggest that it would be safe and worthwhile for larger controlled trials of aerobic training to be undertaken in people with McArdle disease.10

**Pelvic floor rehabilitation**

**Cochrane Incontinence Group**

**Comparisons of approaches to pelvic floor muscle training for urinary incontinence in women.**—The authors screened 574 records for eligibility and included 21 trials in the review. The 21 trials randomised 1490 women and addressed 11 comparisons. These were: differences in training supervision (amount, individual versus group), in approach (one versus another, the effect of an additional component) and the exercise training (type of contraction, frequency of training). In women with stress urinary incontinence, 10% of those who received weekly or twice-weekly group supervision in addition to individual appointments with the therapist did not report improvement post-treatment compared to 45% of the group who had individual appointments only (risk ratio (RR) for no improvement 0.29, 95% CI 0.15 to 0.55, four trials). Looking at this another way, 90% of those who had combined group and individual supervision reported improvement versus 57% of women receiving individual supervision only. While women receiving the combination of frequent group supervision and individual supervision of pelvic floor muscle training were more likely to report improvement, the confidence interval was wide, and more than half of the ‘control’ group (the women who did not get the additional weekly or twice-weekly group supervision) reported improvement. This finding, of subjective improvement in both active treatment groups, with more improvement reported by those receiving more health professional contact, was consistent throughout the review. According to the authors there are several reasons why caution is needed when interpreting the results of the review: there were few data in any comparison; a number of trials were confounded by comparing two arms with multiple differences in the approaches to pelvic floor muscle training, there was a likelihood of a relationship between attention and reporting of improvement in women who were not blind to treatment allocation; some trials chose interventions that were unlikely to have a muscle training effect; and some trials did not adequately describe their intervention.11

This review found that the existing evidence was insufficient to make any strong recommendations about the best approach to pelvic floor muscle training. The authors suggest that women are offered reasonably frequent appointments during the training period, because the few data consistently showed that women receiving regular (e.g. weekly) supervision were more likely to report improvement than women doing pelvic floor muscle training with little or no supervision.11

**Updated reviews**

**Neurological Rehabilitation**

**Cochrane Neuromuscular Disease Group**

**Physical therapy for Bell’s palsy (idiopathic facial paralysis).**—For this update to the original review, the search identified 65 potentially relevant articles. Twelve studies met the inclusion criteria (872 participants). Four trials studied the efficacy of electrical stimulation (315 participants), three trials studied exercises (199 participants), and five studies com-
pared or combined some form of physical therapy with acupuncture (360 participants). For most outcomes we were unable to perform meta-analysis because the interventions and outcomes were not comparable. For the primary outcome of incomplete recovery after six months, electrostimulation produced no benefit over placebo (moderate quality evidence from one study with 86 participants). Low quality comparisons of electrostimulation with prednisolone (an active treatment) (149 participants), or the addition of electrostimulation to hot packs, massage and facial exercises (22 participants), reported no significant differences. Similarly a meta-analysis from two studies, one of three months and the other of six months duration, (142 participants) found no statistically significant difference in synkinesis, a complication of Bell's palsy, between participants receiving electrostimulation and controls. A single low quality study (56 participants), which reported at three months, found worse functional recovery with electrostimulation (mean difference (MD) 12.00 points (scale of 0 to 100), 95% CI 1.26 to 22.74). Two trials of facial exercises, both at high risk of bias, found no difference in incomplete recovery at six months when exercises were compared to waiting list controls or conventional therapy. There is evidence from a single small study (34 patients) of moderate quality that exercises are beneficial on measures of facial disability to people with chronic facial palsy when compared with controls (MD 20.40 points (scale of 0 to 100), 95% CI 8.76 to 32.04) and from another single low quality study with 145 people with acute cases treated for three months where significantly fewer participants developed facial motor synkinesis after exercise (risk ratio 0.24, 95% CI 0.08 to 0.69). The same study showed statistically significant reduction in time for complete recovery, mainly in more severe cases (47 participants, MD -2.10 weeks, 95% CI -3.15 to -1.05) but this was not a prespecified outcome in this meta-analysis. Acupuncture studies did not provide useful data as all were short and at high risk of bias. None of the studies included adverse events as an outcome.

There is no high quality evidence to support significant benefit or harm from any physical therapy for idiopathic facial paralysis. There is low quality evidence that tailored facial exercises can help to improve facial function, mainly for people with moderate paralysis and chronic cases. There is low quality evidence that facial exercise reduces sequelae in acute cases. The suggested effects of tailored facial exercises need to be confirmed with good quality randomised controlled trials.12

Pelvic floor rehabilitation

COCHRANE INCONTINENCE GROUP

Conservative prevention and management of pelvic organ prolapse in women.—Six trials were included; three of these trials are new to this update. Four trials were small (less than 25 women per arm) and two had moderate to high risk of bias. Four trials compared pelvic floor muscle training (PFMT) as a treatment for prolapse against a control group (n = 857 women); two trials included women having surgery for prolapse and compared PFMT as an adjunct to surgery versus surgery alone (N = 118 women). PFMT versus control There was a significant risk of bias in two out of four trials in this comparison. Prolapse symptoms and women's reports of treatment outcomes (primary outcomes) were measured differently in the three trials where this was reported: all three indicated greater improvement in symptoms in the PFMT group compared to the control group. Pooling data on severity of prolapse from two trials indicated that PFMT increases the chance of an improvement in prolapse stage by 17% compared to no PFMT. The two trials which measured pelvic floor muscle function found better function (or improvement in function) in the PFMT group compared to the control group; measurements were not known to be blinded. Two out of three trials which measured urinary outcomes (urodynamics, frequency and bother of symptoms or symptom score) reported differences between groups in favour of the PFMT group. One trial reported bowel outcomes, showing less frequency and bother with symptoms in the PFMT group compared to the control group. PFMT supplementing surgery versus surgery alone both trials were small and neither measured prolapse-specific outcomes. Pelvic floor muscle function findings differed between the trials: one found no difference between trial groups in muscle strength, whilst the other found a benefit for the PFMT group in terms of stronger muscles. Similarly findings relating to urinary outcomes were contradictory: one trial found no difference in symptom score change between groups, whilst the other found more improvement in urinary symptoms and...

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a reduction in diurnal frequency in the PFMT group compared to the control group. The largest most rigorous trial to date suggests that six months of supervised PFMT has benefits in terms of anatomical and symptom improvement (and symptomatic) immediately post-intervention. Further evidence relating to effectiveness and cost-effectiveness of PFMT, of different intensities, for symptomatic prolapse in the medium and long term is needed. A large trial of PFMT supplementing surgery is needed to give clear evidence about the usefulness of combining these treatments. Other comparisons which have not been addressed in trials to date and warrant consideration include those involving lifestyle change interventions, and trials aimed at prolapse prevention.13

Discussion

As usually happens, neurological rehabilitation is one of the fields about which the Cochrane collaboration products most reviews. Despite the interest for frequent pathologies like Cerebral Palsy or Bell’s Paralysis,12 also rare diseases have been investigated through interventions reviews. This is the case of Mc Ardle Disease.10

About the Pelvic Floor Rehabilitation, two reviews were found, showing that also this field is of increased relevance for rehabilitation.11,13

Conclusions

The field of Rehabilitation, being cross-sectional to the whole Medicine, can be of interest for many specialties. This was documented by the large number of Cochrane Group publishing reviews of rehabilitative interest. Reviewing periodically the Cochrane reviews is a good way to remain up to date and to find solid bases for everyday clinical practice (Appendix 1).

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