Stroke rehabilitation

**Title**  Clinical guidelines for stroke rehabilitation and recovery

**Date of latest update**  September, 2005

**Review and update by**  2010

**Patient group**  People with stroke after the acute phase

**Intended audience**  Doctors, nurses, physiotherapists, occupational therapists, speech pathologists, dietitians, social workers

**Additional documents**  Two consumer versions, one for the hospital-based phase and one for the community-based phase.

**Country of origin**  Australia

**Funded by**  National Stroke Foundation of Australia

**Consultation with**  Feedback was received from 60 professional bodies, health professionals, consumer organisations, and consumers.

**Approved by**  National Health and Medical Research Council of Australia, Australasian Faculty of Rehabilitation Medicine, Australasian Stroke Unit Network, Australian College of Rural and Remote Medicine, Australian Physiotherapy Association, Australian Society for Geriatric Medicine, Dietitians Association of Australia, Occupational Therapy Australia, Royal Australian and New Zealand College of Radiologists, Royal College of Nursing, Speech Pathology Australia, Stroke Society of Australasia, The Royal Australian and New Zealand College of Psychiatrists

**Description**  71 page document. Key messages are summarised in 12 pages at the beginning of the document. The guidelines are organised into five sections: organisation of care; discharge planning, transfer of care and co-ordinated community care; management of the consequences of stroke; living with stroke; and resource implications. The guidelines are supported by 426 references. The part of the document most relevant to physiotherapists is pp 15–23 which cover intervention for reducing sensorimotor impairments (weakness, loss of sensation, spasticity, contracture, subluxation of the shoulder, shoulder pain, swelling of the extremities, cardiovascular fitness, falling) and improving activity (sitting, standing up from a chair, standing, walking, upper limb activity) as well as the amount of practice. Of the 47 recommendations, 13 are based on Level I evidence (systematic review), 16 are based on Level II evidence (randomised controlled trial), 14 are based on Level III evidence (non-randomised, case control, time series studies), 1 is based on Level IV evidence (pre-post case series), and 3 are based on consensus by the expert working group.


Acute musculoskeletal pain

**Title**  Evidence-based management of acute musculoskeletal pain – A guide for clinicians

**Date of latest update**  December 2003

**Patient group**  People with acute (<3 months) musculoskeletal pain

**Intended audience**  Doctors, physiotherapists, chiropractors, osteopaths

**Additional documents**  Evidence-based management of acute musculoskeletal pain (259 page source document). Five patient information sheets accompany this guide: acute low back pain, acute thoracic spinal pain, acute neck pain, acute shoulder pain, and acute knee pain. These sheets are designed to be downloaded and photocopied for patients.

**Country of origin**  Australia

**Funded by**  Commonwealth Department of Health and Ageing Australia

**Consultation with**  Feedback was received from 42 professional bodies, health professionals, consumer organisations, and consumers

**Approved by**  National Health and Medical Research Council of Australia, Australian and New Zealand College of Anaesthetists, Faculty of Pain Medicine, Australian Osteopathic Association, Australian Rheumatology Association, Australian Physiotherapy Association, Chiropractic and Osteopathic College of Australasia, Chiropractors’ Association of Australia, Consumers’ Health Forum of Australia, Royal Australian College of General Practice

**Description**  83 page document. The guidelines can be divided into 2 main sections. The first (Chapters 1–4), provides general information about principles of acute pain management, effective communication, and a management plan for acute musculoskeletal pain. The second (Chapters 5–9), outlines the key findings in 5 conditions: acute low back pain, acute thoracic spinal pain, acute neck pain, acute shoulder pain, and anterior knee pain. In each of these chapters, a definition of the problem addressed, the scope of the guidelines, and any red flags (alerting features and risk factors of serious conditions) are given. Then the key findings regarding diagnosis, prognosis, and interventions are given. These sections (pp 18–58) are the most relevant to physiotherapists. Levels of evidence for intervention are given as evidence of benefit, conflicting evidence, and insufficient evidence. Interventions relevant to physiotherapy covered are exercise, mobilisations, manipulation, electrotherapy, rest, advice to stay active and group exercise programs (eg, back school). Appendices (A–D) include an outline of pain assessment tools, a guide for appropriate investigations (eg, MRI, bone scan) for possible serious causes of acute musculoskeletal pain, the Canadian C-spine rule which gives indicators for radiography with cervical spine pain and injury, and three different rules for indicators for X-ray with knee pain.

**Location**  Download from www.nhmrc.gov.au publications.