

ΝΕΟΤΕΡΕΣ ΚΑΤΕΥΘΥΝΤΗΡΙΕΣ ΟΔΗΓΙΕΣ ΣΤΗΝ ΑΠΟΚΑΤΑΣΤΑΣΗ ΑΣΘΕΝΩΝ ΜΕΤΑ ΑΠΟ ΑΓΓΕΙΑΚΟ ΕΓΚΕΦΑΛΙΚΟ ΕΠΕΙΣΟΔΙΟ ΚΑΤΑ ΤΗΝ ΕΝΔΟΝΟΣΟΚΟΜΕΙΑΚΗ ΦΑΣΗ.



Αλέξανδρος Κουβαράκος, MSc, φυσικοθεραπευτής Γ.Ν.Α. «Ευαγγελισμός»



24^ο

Ετήσιο Σεμινάριο Συνεχιζόμενης
Ιατρικής Εκπαίδευσης
Νοσοκομείου «Ο Ευαγγελισμός»

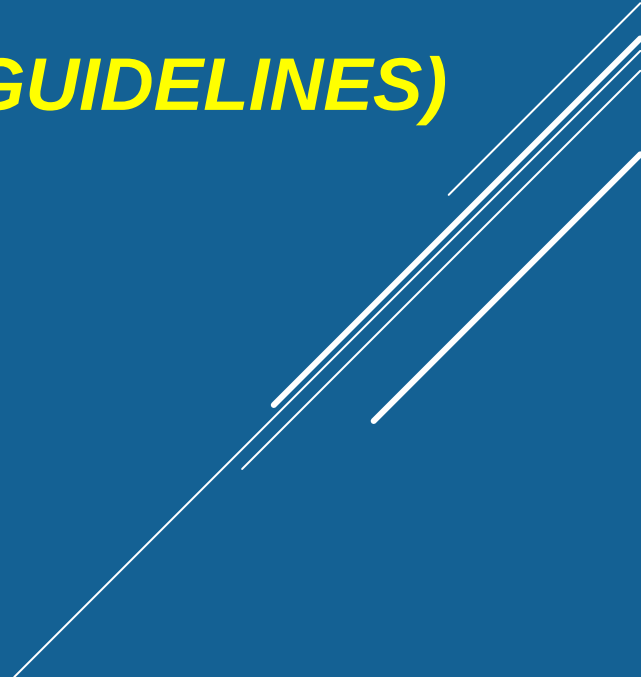


Αθήνα, 18 - 22 Φεβρουαρίου 2019

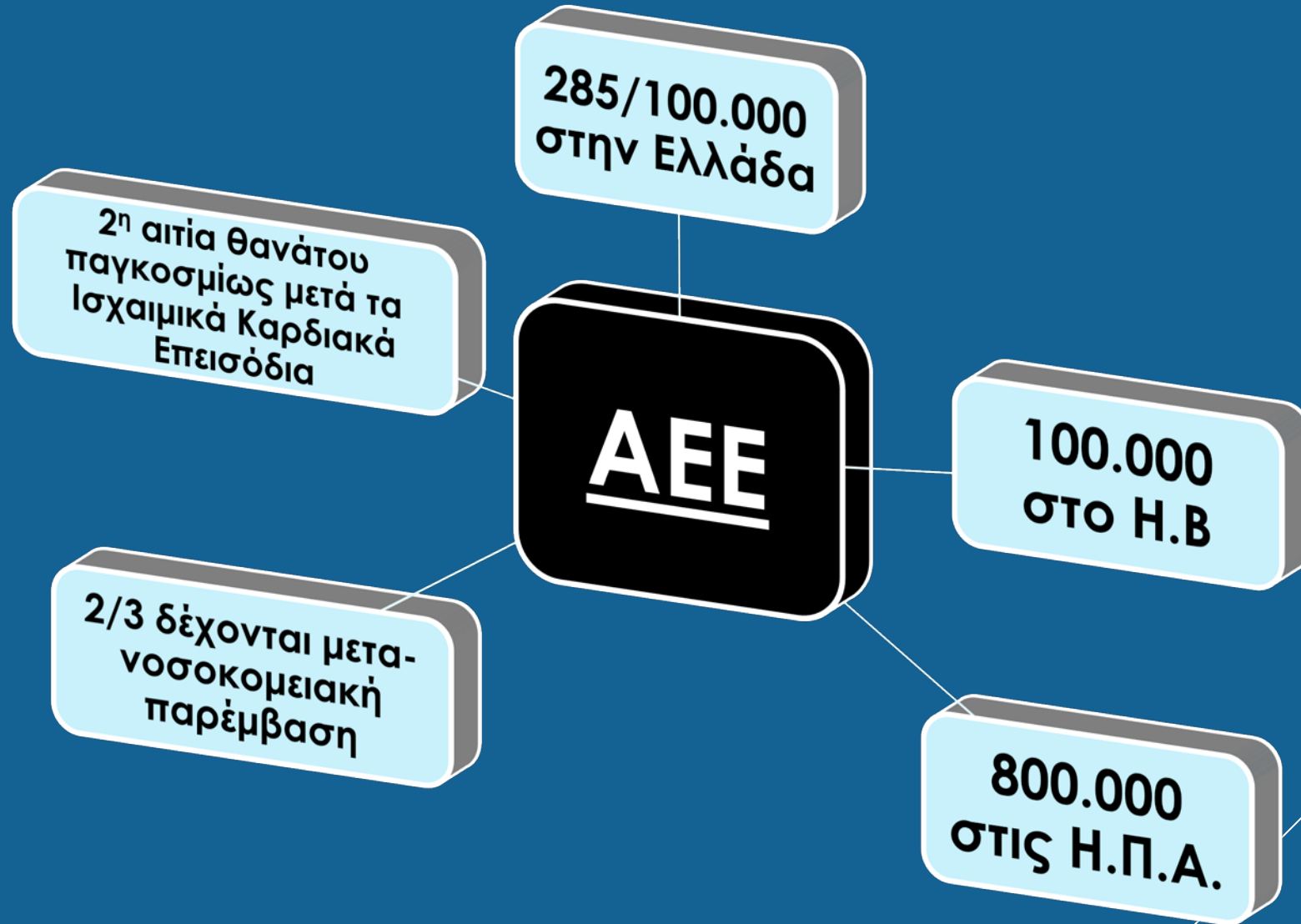
Δεν υπάρχει σύγκρουση συμφερόντων
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ΔΙΑΘΡΩΣΗ ΠΑΡΟΥΣΙΑΣΗΣ

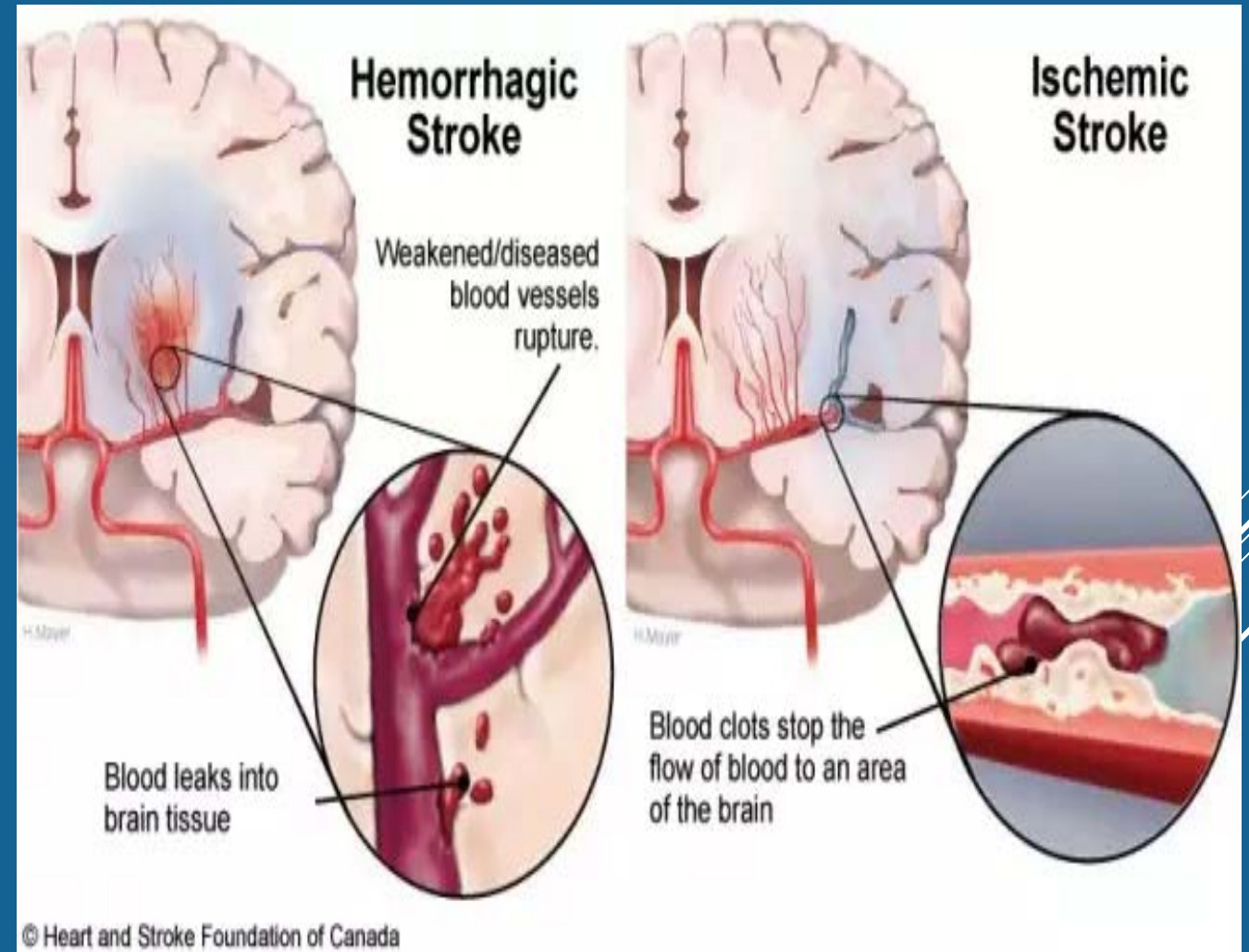
- *Εισαγωγή*
 - *Διαχείριση αποκατάστασης μετά από Αγγειακό Εγκεφαλικό Επεισόδιο (ΑΕΕ)*
 - *Ανάλυση Κατευθυντήριων Οδηγιών (AHA/ASA GUIDELINES)
– Φυσικοθεραπευτική παρέμβαση (Φ/Θ)*
 - *Συμπεράσματα*
- 
- Several thin, white, parallel diagonal lines are positioned in the bottom right corner of the slide, extending from the middle towards the bottom right edge.

ΕΙΣΑΓΩΓΗ



ΕΙΣΑΓΩΓΗ

- Οι επιπτώσεις του κλινοστατισμού εμφανίζονται πρώιμα
- 26% σοβαρή και 43% ελάχιστη αναπηρία 1 χρόνο μετά

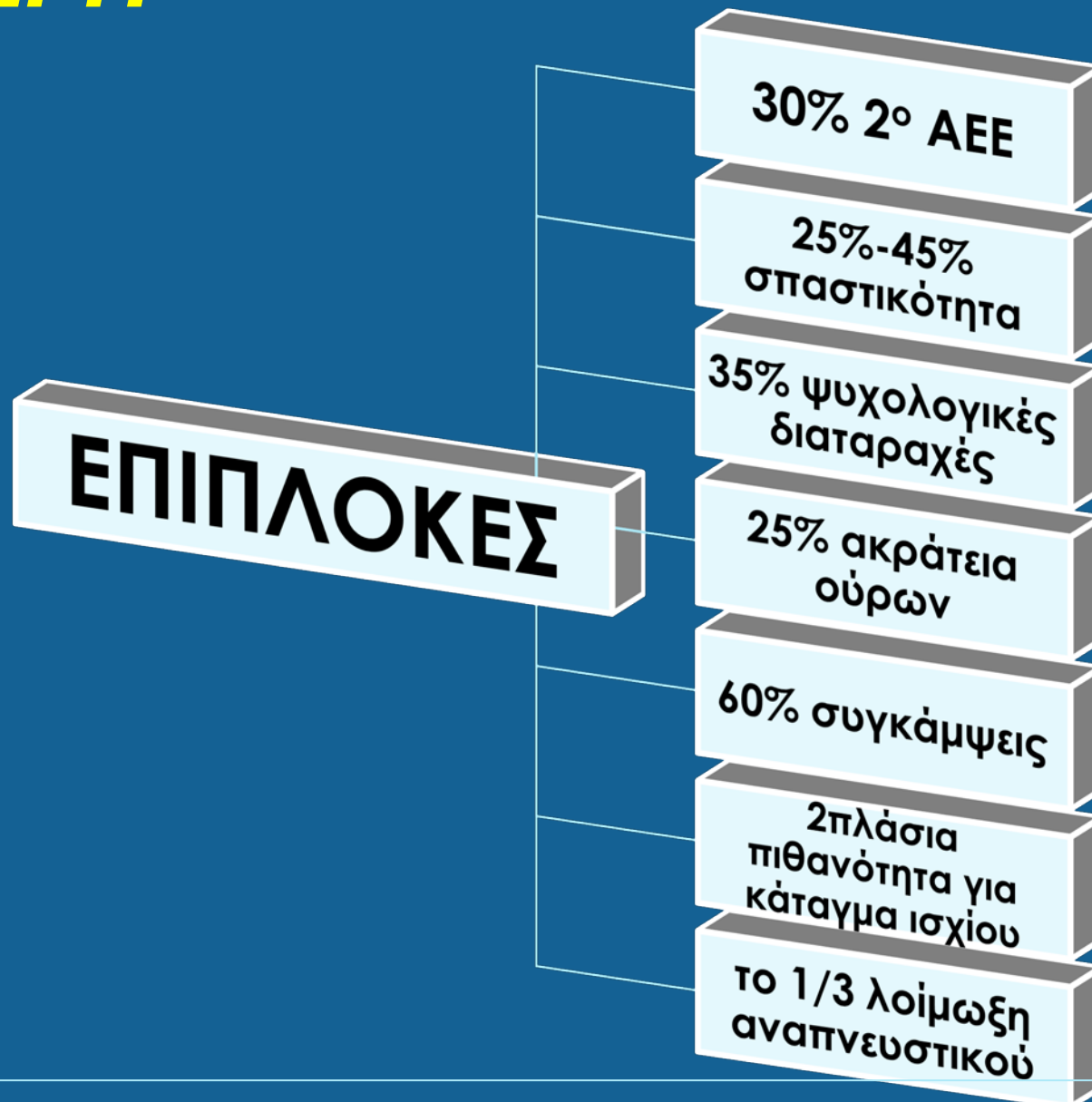


Langhorne P et al, *Stroke* 2000; 31: 1223–1229

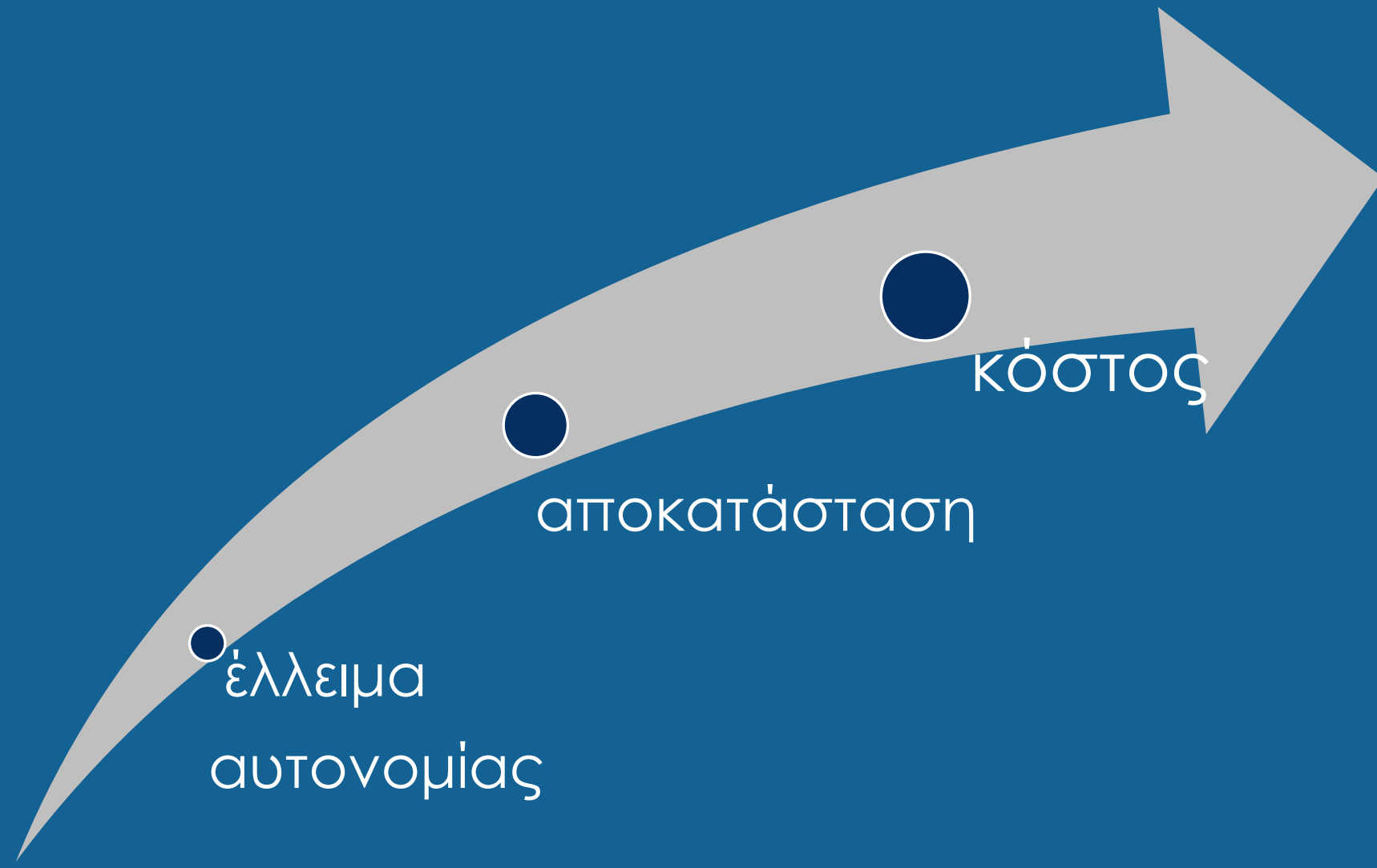
Murphy, TH and Corbett, D *Neurosci.* 2009; 10: 861–872, Krakauer, JW et al. *Neurorehabil Neural Repair.* 2012; 26: 923–931)

Navarrete-Navarro P et al *Intensive Care Med* (2003) 29:1237–1244

ΕΙΣΑΓΩΓΗ



ΕΙΣΑΓΩΓΗ



ΔΙΣ



ΔΙΑΧΕΙΡΙΣΗ ΑΠΟΚΑΤΑΣΤΑΣΗΣ

ΔΙΕΠΙΣΤΗΜΟΝΙΚΗ ΟΜΑΔΑ



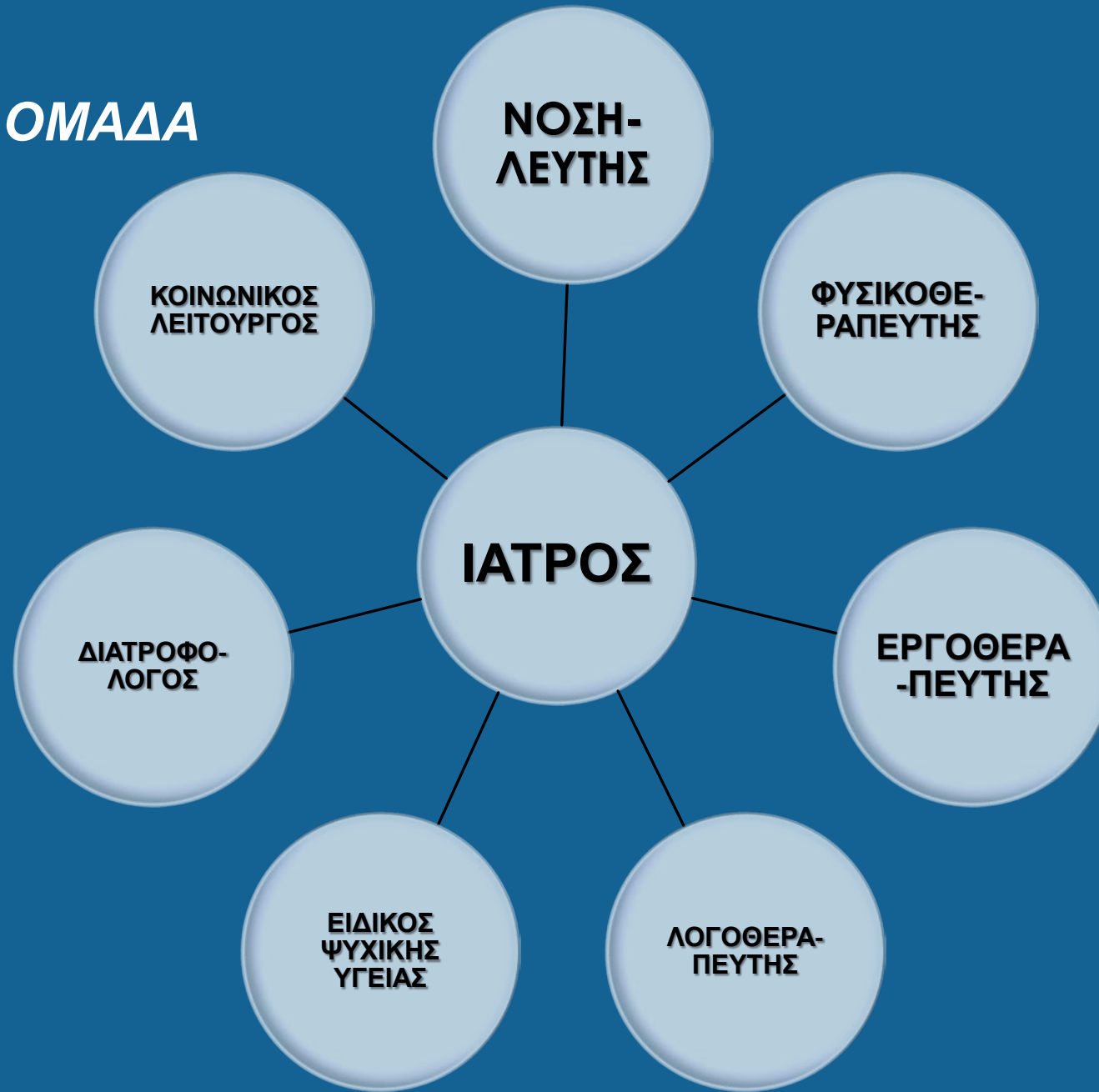
**ΑΣΘΕΝΗΣ -ΣΥΓΓΕΝΕΙΣ-
ΦΡΟΝΤΙΣΤΕΣ- ΚΟΙΝΟΤΗΤΑ**

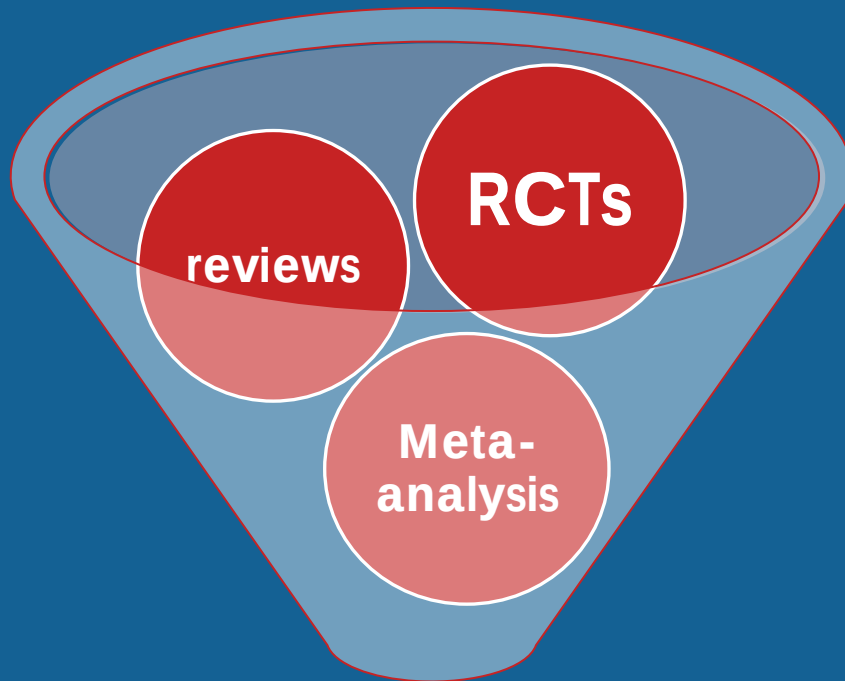


ΕΞΑΤΟΜΙΚΕΥΜΕΝΟΙ ΣΤΟΧΟΙ

ΔΙΑΧΕΙΡΙΣΗ ΑΠΟΚΑΤΑΣΤΑΣΗΣ

ΔΙΕΠΙΣΤΗΜΟΝΙΚΗ ΟΜΑΔΑ





guidelines

AHA/ASA Guideline

Guidelines for Adult Stroke Rehabilitation and Recovery A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association

Endorsed by the American Academy of Physical Medicine and Rehabilitation and the American Society of Neurorehabilitation

The American Academy of Neurology affirms the value of this guideline as an educational tool for neurologists and the American Congress of Rehabilitation Medicine also affirms the educational value of these guidelines for its members

Carolee J. Winstein, PhD, PT, Chair; Joel Stein, MD, Vice Chair;
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Mathew J. Reeves, PhD, DVM, FAHA; Lorie G. Richards, PhD, OTR/L; William Stiers, PhD, ABPP (RP);
Richard D. Zorowitz, MD; on behalf of the American Heart Association Stroke Council, Council on Cardiovascular and Stroke Nursing, Council on Clinical Cardiology, and Council on Quality of Care and Outcomes Research

Purpose—The aim of this guideline is to provide a synopsis of best clinical practices in the rehabilitative care of adults recovering from stroke.

Methods—Writing group members were nominated by the committee chair on the basis of their previous work in relevant topic areas and were approved by the American Heart Association (AHA) Stroke Council's Scientific Statement Oversight Committee and the AHA's Manuscript Oversight Committee. The panel reviewed relevant articles on adults using computerized searches of the medical literature through 2014. The evidence is organized within the context of the AHA framework and is classified according to the joint AHA/American College of Cardiology and supplementary AHA methods of classifying the level of certainty and the class and level of evidence. The document underwent extensive AHA internal and external peer review, Stroke Council Leadership review, and Scientific Statements Oversight Committee review before consideration and approval by the AHA Science Advisory and Coordinating Committee.

Results—Stroke rehabilitation requires a sustained and coordinated effort from a large team, including the patient and his or her goals, family and friends, other caregivers (eg, personal care attendants), physicians, nurses, physical and occupational therapists, speech-language pathologists, recreation therapists, psychologists, nutritionists, social workers, and others. Communication and coordination among these team members are paramount in maximizing the effectiveness and efficiency of rehabilitation and underlie this entire guideline. Without communication and coordination, isolated efforts to rehabilitate the stroke survivor are unlikely to achieve their full potential.

The American Heart Association makes every effort to avoid any actual or potential conflicts of interest that may arise as a result of an outside relationship or a personal, professional, or business interest of a member of the writing panel. Specifically, all members of the writing group are required to complete and submit a Disclosure Questionnaire showing all such relationships that might be perceived as real or potential conflicts of interest.

This guideline was approved by the American Heart Association Science Advisory and Coordinating Committee on January 4, 2016, and the American Heart Association Executive Committee on February 23, 2016. A copy of the document is available at <http://professional.heart.org/statements> by using either "Search for Guidelines & Statements" or the "Browse by Topic" area. To purchase additional reprints, call 843-216-2533 or e-mail kelle.ramsay@wolterskluwer.com.

The American Heart Association requests that this document be cited as follows: Winstein CJ, Stein J, Arena R, Bates B, Cherney LR, Cramer SC, Deruyter F, Eng JJ, Fisher B, Harvey RL, Lang CE, MacKay-Lyons M, Ottenbacher KJ, Pugh S, Reeves MJ, Richards LG, Stiers W, Zorowitz RD; on behalf of the American Heart Association Stroke Council, Council on Cardiovascular and Stroke Nursing, Council on Clinical Cardiology, and Council on Quality of Care and Outcomes Research. Guidelines for adult stroke rehabilitation and recovery: a guideline for healthcare professionals from the American Heart Association/American Stroke Association. *Stroke*. 2016;47:XXX-XXX. DOI: 10.1161/STR.0000000000000098.

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DOI: 10.1161/STR.0000000000000098

ΑΗΑ/ΑΣΑ GUIDELINES- ΟΡΓΑΝΩΣΗ ΑΠΟΚΑΤΑΣΤΑΣΗΣ

Οργάνωση αποκατάστασης:

- νοσοκομείο
- κέντρα αποκατάστασης κλειστού τύπου
- κέντρα εξειδικευμένης νοσηλευτικής φροντίδας
- κέντρα ή νοσοκομεία μακράς νοσηλείας
- προγράμματα κατ' οίκον αποκατάστασης

Appendix 1. Structure and Organization of Stroke Rehabilitation Care in the United States

Setting	Admission	Median Length of Stay	Specialist Involvement
Acute inpatient facility (hospital)	Near onset	4 d for ischemic stroke 7 d for hemorrhagic stroke	Major: MD, RN More limited: OT, PT, SLT, SW
IRF	5–7 d	15 d (range, 8–30 d)	Major: MD, RN, OT, PT, SLT More limited: SW
SNF	5–7 d	Highly variable (maximum, 100 d)	Major: LPN/LVN, NA, OT, PT, SLT More limited: MD, RN
Long-term care (nursing home)	Highly variable	Prolonged and highly variable	Major: LPN/LVN, NA More limited: RN, OT, PT, SLT, MD
Long-term care hospital	Variable	25-d average (required)	Major: RN, MD More limited: OT, PT, SLT
HHCA	Variable (typically 5–30 d)	Maximum 60-d episode	Major: NA, RN More limited: OT, PT, SLT, MD
Outpatient office	Variable (typically 5–30 d)	Variable	Major: OT, PT, SLT, MD

HHCA indicates home healthcare agency; IRF, inpatient rehabilitation facility; LPN/LVN, licensed practical or vocational nurse; MD, medical doctor; NA, nurse assistant; OT, occupational therapist; PT, physical therapist; RN, registered nurse (preferably with training in rehabilitation); SLT, speech-language therapist; SNF, skilled nursing facility; and SW, social worker. Modified from Miller et al.¹¹ Copyright © 2010, American Heart Association, Inc.

ΑΗΑ/ΑSΑ GUIDELINES- ΠΡΩΙΜΗ ΑΞΙΟΛΟΓΗΣΗ - ΠΑΡΕΜΒΑΣΗ

- Ιστορικό
- Παρατήρηση- Επισκόπηση- ψηλάφηση
- Ακρόαση- ακτινογραφία θώρακος
- Αξιολόγηση μυοσκελετικού συστήματος
- Επίπεδο επικοινωνίας
- Φαρμακευτική αγωγή

Μελέτη	πληθυσμός	Χρόνος έναρξης	παρέμβαση	αποτελέσματα
Bernhardt et al 2008 (AVERT)	71(87%ισχαιμικό)	24h	Ορθοστάτιση- Κάθισμα εκτός κλίνης (2φ/ημέρα)	Χωρίς επιπλοκές, Βελτίωση λειτουργικότητας (p=0,05)και 3m μετά
Langhorne et al 2010 (VERITAS)	32	24h	Ορθοστάτιση-βάδιση- κάθισμα εκτός κλίνης	Χωρίς επιπλοκές
Diserens et al 2011(Lausanne trial)	50	52h	Έγερση κεφαλής σταδιακή-κινητοποίηση μετά 52h	Χωρίς επιπλοκές
Sundseth et al 2012 (AKEMIS)	65	24h	Δραστηριότητες εκτός κλίνης	Ομάδα ελέγχου (ηπιότερο ΑΕΕ): λιγότερους θανάτους, καλύτερη νευρολογική εικόνα

ΑΗΑ/ASA GUIDELINES- ΠΡΩΙΜΗ ΑΞΙΟΛΟΓΗΣΗ - ΠΑΡΕΜΒΑΣΗ



ΕΡΓΑΛΕΙΑ ΑΞΙΟΛΟΓΗΣΗΣ

Μυϊκή ισχύς

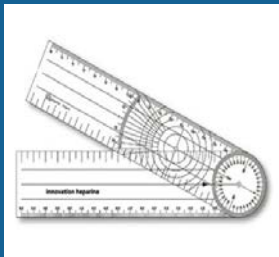
Μυϊκά test

Δυναμόμετρο
χειρός



Εύρος κίνησης

γωνιόμετρο



Μυϊκός τόνος

Modified
Anshworth
Scale

Άνω-Κάτω άκρο

Action
Research Arm
Test

Box and
Block Test

Fugl – Meyer
Scale

Chedoke Arm
Hand Activity
Index

Wolf Motor
Function Test

Ισορροπία- Πρόληψη Πτώσεων

Berg Balance
Scale

Morse Falls
Scale

Functional
Reach Test

Postural
Assessment
Scale

Κινητικότητα

Walking
Speed

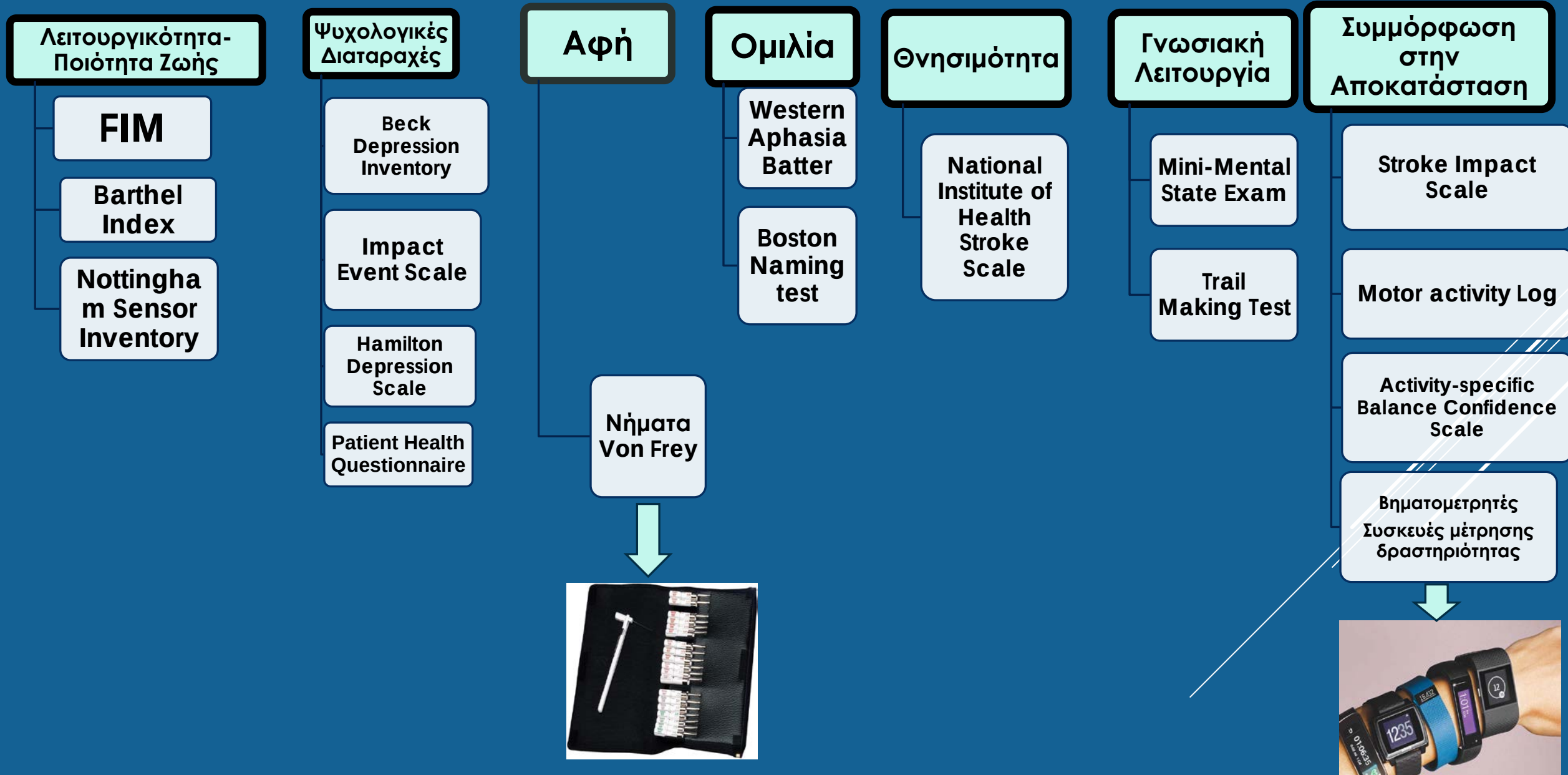
Timed Up
and Go

6min or
10min walk
test

Functional
Ambulation
Category

Observational
Gait Analysis

ΕΡΓΑΛΕΙΑ ΑΞΙΟΛΟΓΗΣΗΣ



ΑΗΑ/ΑΣΑ GUIDELINES – ΑΝΤΙΜΕΤΩΠΙΣΗ ΣΥΓΚΑΜΨΕΩΝ ΚΑΙ ΔΕΡΜΑΤΙΚΩΝ ΒΛΑΒΩΝ

- 60% θα εμφανίσουν συγκάμψεις
- Εκπαίδευση και ενημέρωση ασθενών και συγγενών για πρόληψη αυτών των επιπλοκών
- Πρόγραμμα ασκήσεων
- Αξιολόγηση δερματικών επιφανειών
- Χειρουργική αποκατάσταση

Recommendations: Prevention of Skin Breakdown and Contractures	Class	Level of Evidence
During hospitalization and inpatient rehabilitation, regular skin assessments are recommended with objective scales of risk such as the Braden scale.	I	C
It is recommended to minimize or eliminate skin friction, to minimize skin pressure, to provide appropriate support surfaces, to avoid excessive moisture, and to maintain adequate nutrition and hydration to prevent skin breakdown. Regular turning, good skin hygiene, and use of specialized mattresses, wheelchair cushions, and seating are recommended until mobility returns.	I	C
Patients, staff, and caregivers should be educated about the prevention of skin breakdown.	I	C
Positioning of hemiplegic shoulder in maximum external rotation while the patient is either sitting or in bed for 30 minutes daily is probably indicated.	IIa	B
Resting hand/wrist splints, along with regular stretching and spasticity management in patients lacking active hand movement, may be considered.	IIb	C
Use of serial casting or static adjustable splints may be considered to reduce mild to moderate elbow and wrist contractures.	IIb	C
Surgical release of brachialis, brachioradialis, and biceps muscles may be considered for substantial elbow contractures and associated pain.	IIb	B
Resting ankle splints used at night and during assisted standing may be considered for prevention of ankle contracture in the hemiplegic limb.	IIb	B

ΑΗΑ/ΑΣΑ GUIDELINES – ΑΝΤΙΜΕΤΩΠΙΣΗ ΣΥΓΚΑΜΨΕΩΝ ΚΑΙ ΔΕΡΜΑΤΙΚΩΝ ΒΛΑΒΩΝ

Lying on Hemiplegic Side



- Hemiplegic arm forward at the shoulder; elbow extended and hand supported with the palm up
- Unaffected arm supported forward on the pillow
- Pillow behind back
- Both legs bent at the hips and knees; pillow in between

Lying on Unaffected Side



- Hemiplegic arm supported forward on two pillows
- Pillow behind back
- Both legs bent at the hips and knees, a pillow in between

Sitting in Bed

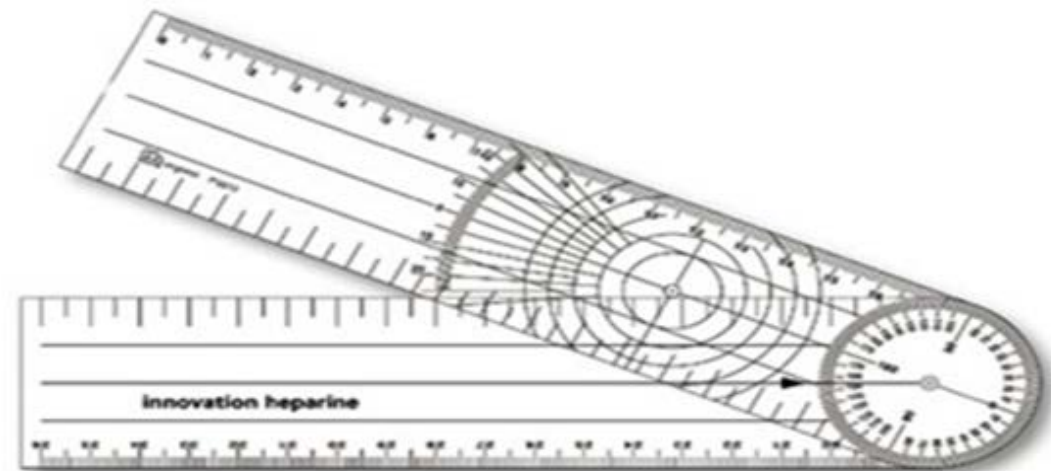


- Hemiplegic arm supported on two pillows
- Trunk in midline
- Pillows under unaffected arm as required

Sitting in Wheelchair



- Lap tray on wheelchair
- Pillow under hemiplegic arm with shoulder abducted, forearm pointing forward and hand supported



ΑΗΑ/ΑSΑ GUIDELINES – ΑΝΤΙΜΕΤΩΠΙΣΗ ΣΥΓΚΑΜΨΕΩΝ ΚΑΙ ΔΕΡΜΑΤΙΚΩΝ ΒΛΑΒΩΝ



BRADEN SCALE –Pressure Sore Risk

Sensory perception, <i>ability to respond to pressure related discomfort effectively</i>				
1. Completely limited: Unresponsive	2. Very limited: Responds only to painful stimuli.	3. Slightly limited: Responds to verbal commands, cannot ask to turn	4. No impairment: no sensory deficit limiting expression of discomfort	Score
Moisture, <i>degree to which skin is exposed to moisture</i>				Score
1. Constantly moist	2. Very moist	3. Occasionally moist	4. Rarely moist	Score
Activity, <i>degree of physical activity</i>				Score
1. Bedfast	2. Chair fast	3. Walks occasionally	4. Walks often	Score
Mobility, <i>ability to change and Control Position</i>				Score
1. Completely immobile	2. Very limited	3. slightly limited	4. No limitation	Score
Nutrition, <i>usual food intake pattern</i>				Score
1. Very poor	2. Probably inadequate	3. Adequate	4. Excellent	Score
Friction and shear				Score
1. Problem	2. Potential problem	3. No apparent problem		Score
15-18 Low Risk, 13-14 Moderate Risk, 10-12 High Risk, >9 Very High Risk				TOTAL

Stage I: A reddened area on the skin that, when pressed, is "non-blanchable" (does not turn white). This indicates that a pressure ulcer is starting to develop.

Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated.

Stage III: The skin breakdown now looks like a crater where there is damage to the tissue below the skin.

Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes tendons and joints



ΑΗΑ/ΑΣΑ GUIDELINES – ΑΝΤΙΜΕΤΩΠΙΣΗ ΥΠΕΡΤΟΝΙΑΣ

- 25% με 45% σε οποιοδήποτε άκρο
- 4πλάσια αύξηση κόστους αποκατάστασης
- Αξιολόγηση υπερτονίας
- Ενδομυϊκή χορήγηση αλλαντικής τοξίνης (Botox)
- Όχι νάρθηκες ηρεμίας καρπού και δαχτύλων.

Recommendations: Spasticity	Class	Level of Evidence
Targeted injection of botulinum toxin into localized upper limb muscles is recommended to reduce spasticity, to improve passive or active range of motion, and to improve dressing, hygiene, and limb positioning.	I	A
Targeted injection of botulinum toxin into lower limb muscles is recommended to reduce spasticity that interferes with gait function.	I	A
Oral antispasticity agents can be useful for generalized spastic dystonia but may result in dose-limiting sedation or other side effects.	IIa	A
Physical modalities such as NMES or vibration applied to spastic muscles may be reasonable to improve spasticity temporarily as an adjunct to rehabilitation therapy.	IIb	A
Intrathecal baclofen therapy may be useful for severe spastic hypertonia that does not respond to other interventions.	IIb	A
Postural training and task-oriented therapy may be considered for rehabilitation of ataxia.	IIb	C
The use of splints and taping are not recommended for prevention of wrist and finger spasticity after stroke.	III	B

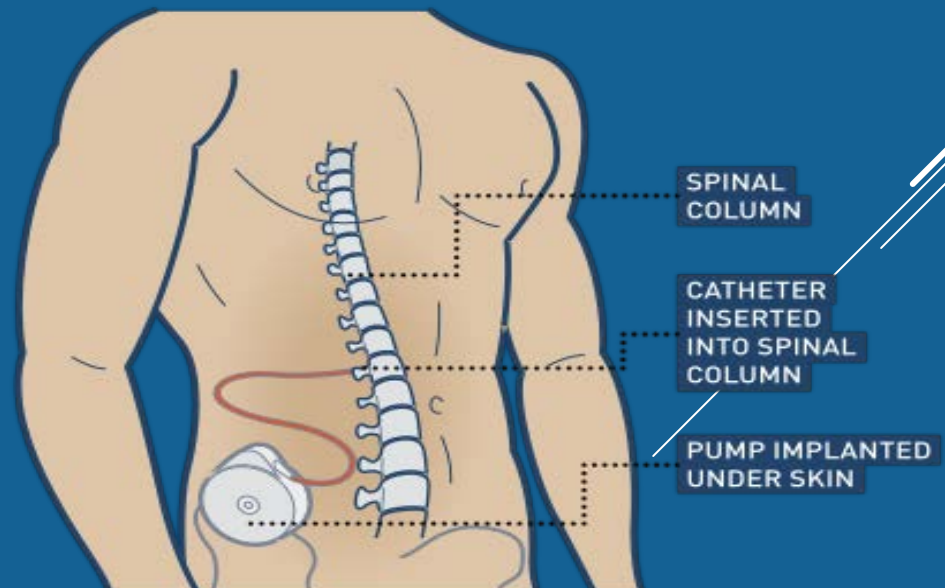
AHA/ASA GUIDELINES – ANΤΙΜΕΤΩΠΙΣΗ ΥΠΕΡΤΟΝΙΑΣ

Modified Ashworth Scale

0	No increase in muscle tone
1	Slight increase in muscle tone, manifested by a catch and release or by minimal resistance at the end range of motion when the part is moved in flexion or extension/abduction or adduction, etc.
1+	Slight increase in muscle tone, manifested by a catch, followed by minimal resistance throughout the remainder (less than half) of the ROM
2	marked increase in muscle tone through most of the ROM, but the affected part is easily moved
3	Considerable increase in muscle tone, passive movement is difficult
4	Affected part is rigid in flexion or extension (abduction or adduction, etc.)



ΑΗΑ/ΑΣΑ GUIDELINES – ΑΝΤΙΜΕΤΩΠΙΣΗ ΥΠΕΡΤΟΝΙΑΣ



AHA/ASA GUIDELINES – ΚΙΝΗΤΙΚΟΤΗΤΑ ΚΑΤΩ ΑΚΡΩΝ

- Προγράμματα ασκήσεων ενδυνάμωσης, ισορροπίας, λειτουργικότητας, επανεκπαίδευσης βάδισης.
- Χρήση βοηθητικών μέσων (νάρθηκας έσω υποδήματος)

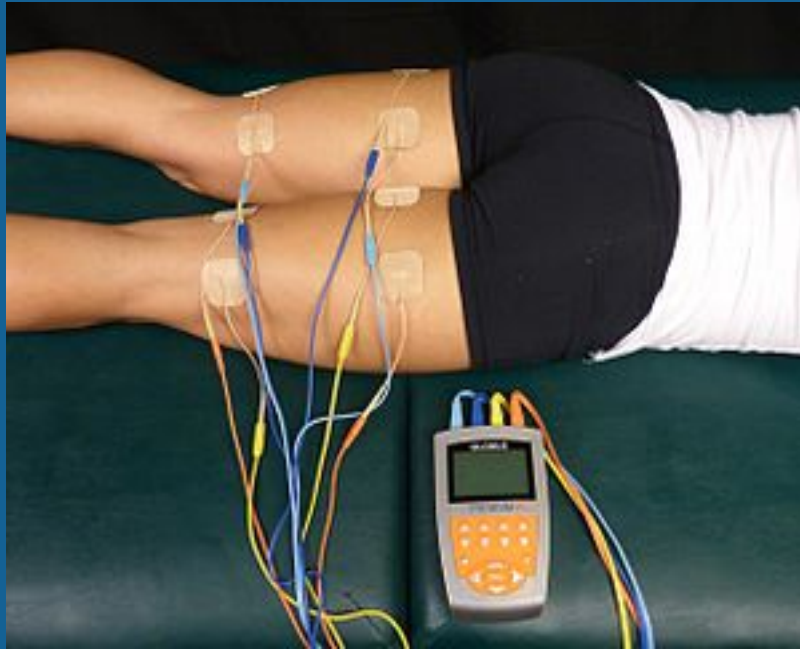
Recommendations: Mobility	Class	Level of Evidence
Intensive, repetitive, mobility- task training is recommended for all individuals with gait limitations after stroke.	I	A
An AFO after stroke is recommended in individuals with remediable gait impairments (eg, foot drop) to compensate for foot drop and to improve mobility and paretic ankle and knee kinematics, kinetics, and energy cost of walking.	I	A
Group therapy with circuit training is a reasonable approach to improve walking.	IIa	A
Incorporating cardiovascular exercise and strengthening interventions is reasonable to consider for recovery of gait capacity and gait-related mobility tasks.	IIa	A
NMES is reasonable to consider as an alternative to an AFO for foot drop.	IIa	A
Practice walking with either a treadmill (with or without body-weight support) or overground walking exercise training combined with conventional rehabilitation may be reasonable for recovery of walking function.	IIb	A
Robot-assisted movement training to improve motor function and mobility after stroke in combination with conventional therapy may be considered.	IIb	A
Mechanically assisted walking (treadmill, electromechanical gait trainer, robotic device, servo-motor) with body weight support may be considered for patients who are nonambulatory or have low ambulatory ability early after stroke.	IIb	A
There is insufficient evidence to recommend acupuncture for facilitating motor recovery and walking mobility.	IIb	B

Recommendations: Mobility (Continued)	Class	Level of Evidence
The effectiveness of TENS in conjunction with everyday activities for improving mobility, lower extremity strength, and gait speed is uncertain.	IIb	B
The effectiveness of rhythmic auditory cueing to improve walking speed and coordination is uncertain.	IIb	B
The usefulness of electromyography biofeedback during gait training in patients after stroke is uncertain.	IIb	B
Virtual reality may be beneficial for the improvement of gait.	IIb	B
The effectiveness of neurophysiological approaches (ie, neurodevelopmental therapy, proprioceptive neuromuscular facilitation) compared with other treatment approaches for motor retraining after an acute stroke has not been established.	IIb	B
The effectiveness of water-based exercise for motor recovery after an acute stroke is unclear.	IIb	B
The effectiveness of fluoxetine or other SSRIs to enhance motor recovery is not well established.	IIb	B
The effectiveness of levodopa to enhance motor recovery is not well established.	IIb	B
The use of dextroamphetamine or methylphenidate to facilitate motor recovery is not recommended.	II	B

AHA/ASA GUIDELINES – ΚΙΝΗΤΙΚΟΤΗΤΑ ΚΑΤΩ ΑΚΡΩΝ



AHA/ASA GUIDELINES – ΚΙΝΗΤΙΚΟΤΗΤΑ ΚΑΤΩ ΑΚΡΩΝ

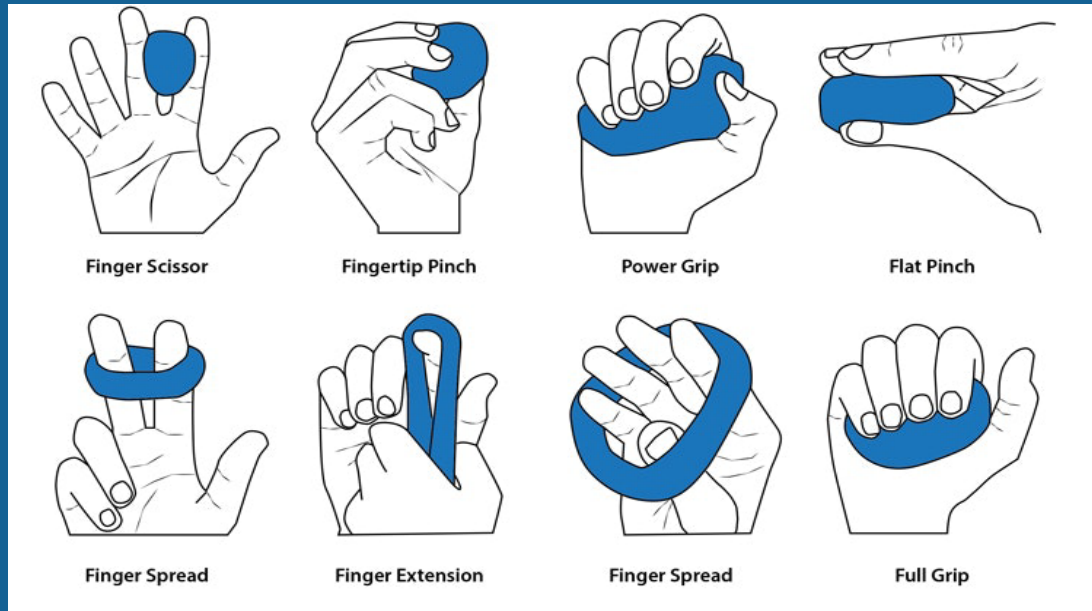


AHA/ASA GUIDELINES – ΚΙΝΗΤΙΚΟΤΗΤΑ ΑΝΩ ΑΚΡΩΝ

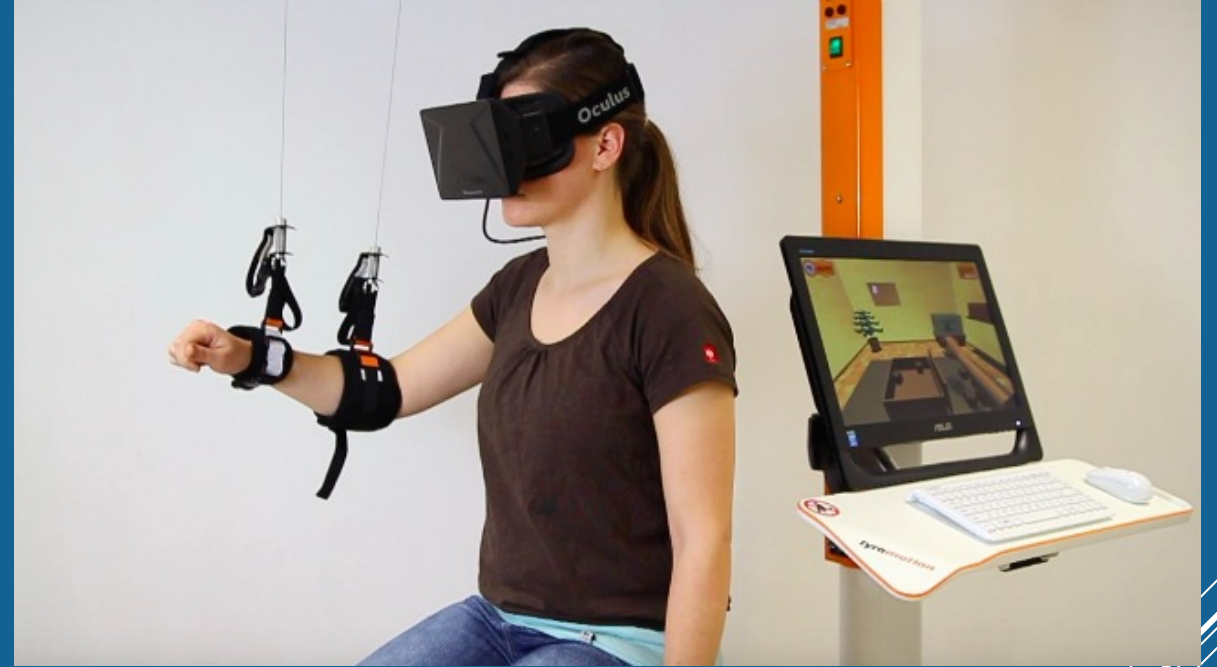
- Προγράμματα ασκήσεων ενδυνάμωσης, λειτουργικότητας, νευρομυϊκής συναρμογής, επανεκπαίδευσης καθημερινών πράξεων άνω άκρου.
- Δεν προτείνεται ο βελονισμός

Recommendations: Upper Extremity Activity, Including ADLs, IADLs, Touch, and Proprioception	Class	Level of Evidence
Functional tasks should be practiced; that is, task-specific training, in which the tasks are graded to challenge individual capabilities, practiced repeatedly, and progressed in difficulty on a frequent basis.	I	A
All individuals with stroke should receive ADL training tailored to individual needs and eventual discharge setting.	I	A
All individuals with stroke should receive IADL training tailored to individual needs and eventual discharge setting.	I	B
CIMT or its modified version is reasonable to consider for eligible stroke survivors.	IIa	A
Robotic therapy is reasonable to consider to deliver more intensive practice for individuals with moderate to severe upper limb paresis.	IIa	A
NMES is reasonable to consider for individuals with minimal volitional movement within the first few months after stroke or for individuals with shoulder subluxation.	IIa	A
Mental practice is reasonable to consider as an adjunct to upper extremity rehabilitation services.	IIa	A
Strengthening exercises are reasonable to consider as an adjunct to functional task practice.	IIa	B
Virtual reality is reasonable to consider as a method for delivering upper extremity movement practice.	IIa	B
Somatosensory retraining to improve sensory discrimination may be considered for stroke survivors with somatosensory loss.	IIb	B
Bilateral training paradigms may be useful for upper limb therapy.	IIb	A
Acupuncture is not recommended for the improvement of ADLs and upper extremity activity.	III	A

AHA/ASA GUIDELINES – ΚΙΝΗΤΙΚΟΤΗΤΑ ΑΝΩ ΑΚΡΩΝ



AHA/ASA GUIDELINES – KINHTIKOTHTA ANΩ AKPΩN



ΑΗΑ/ΑΣΑ GUIDELINES – ΠΡΟΛΗΨΗ ΠΤΩΣΕΩΝ

- 70% ασθενών μετα από ΑΕΕ θα έχουν πτώση
- 27% πιο μεγάλη πιθανότητα για κάταγμα ισχίου ή λεκάνης
- Υψηλό επίπεδο φόβου
- Προγράμματα ισορροπίας και ενδυνάμωσης
- Χρήση βοηθημάτων

Recommendations: Prevention of Falls	Class	Level of Evidence
It is recommended that individuals with stroke discharged to the community participate in exercise programs with balance training to reduce falls.	I	B
It is recommended that individuals with stroke be provided a formal fall prevention program during hospitalization.	I	A
It is reasonable that individuals with stroke be evaluated for fall risk annually with an established instrument appropriate to the setting.	IIa	B
It is reasonable that individuals with stroke and their caregivers receive information targeted to home and environmental modifications designed to reduce falls.	IIa	B
Tai Chi training may be reasonable for fall prevention.	IIb	B
Recommendations: Balance and Ataxia	Class	Level of Evidence
Individuals with stroke who have poor balance, low balance confidence, and fear of falls or are at risk for falls should be provided with a balance training program.	I	A
Individuals with stroke should be prescribed and fit with an assistive device or orthosis if appropriate to improve balance.	I	A
Individuals with stroke should be evaluated for balance, balance confidence, and fall risk.	I	C
Postural training and task-oriented therapy may be considered for rehabilitation of ataxia.	IIb	C

ΑΗΑ/ΑSΑ GUIDELINES – ΠΡΟΛΗΨΗ ΠΤΩΣΕΩΝ



AHA/ASA GUIDELINES – ΠΡΟΛΗΨΗ ΠΤΩΣΕΩΝ



Falls: Morse Fall Scale

The Morse Fall Scale (MFS) is a rapid and simple method of assessing a resident's likelihood of falling. The MFS is used widely in acute care settings.

Resident name: _____ Room #: _____

Medical record #: _____ Date of assessment: _____ Assessment #: _____

Variables		Score
History of falling	☐ No (score as 0)	_____
	☐ Yes (score as 25)	_____
Secondary diagnosis	☐ No (score as 0)	_____
	☐ Yes (score as 15)	_____
Ambulatory aid	☐ Bed rest/nurse assist (score as 0)	_____
	☐ Crutches/cane/walker (score as 15)	_____
	☐ Furniture (score as 30)	_____
IV or IV access	☐ No (score as 0)	_____
	☐ Yes (score as 20)	_____
Gait	☐ Normal/bed rest/immobile (score as 0)	_____
	☐ Weak (score as 10)	_____
	☐ Impaired (score as 20)	_____
Mental status	☐ Knows own limits (score as 0)	_____
	☐ Overestimates or forgets limits (score as 15)	_____
		Total Score

Risk Level	MFS Score	Action
No risk	0 - 24	Good basic nursing care
Low to moderate risk	25 - 45	Implement standard fall prevention interventions using the Falling Leaf Program
High risk	46 +	Implement high-risk fall prevention interventions using the Falling Leaf Program

ΑΗΑ/ΑΣΑ GUIDELINES – ΒΟΗΘΗΤΙΚΑ ΜΕΣΑ

- Η Σύμβαση για τα δικαιώματα ατόμων με αναπηρία των Ηνωμένων Εθνών υποστηρίζει την χρήση βοηθητικών μέσων.



CONVENTION on the RIGHTS of
PERSONS with DISABILITIES

Recommendations: Adaptive Equipment, Durable Medical Devices, Orthotics, and Wheelchairs	Class	Level of Evidence
Ambulatory assistive devices (eg, cane, walker) should be used to help with gait and balance impairments, as well as mobility efficiency and safety, when needed.	I	B
AFOs should be used for ankle instability or dorsiflexor weakness.	I	B
Wheelchairs should be used for nonambulatory individuals or those with limited walking ability.	I	C
Adaptive and assistive devices should be used for safety and function if other methods of performing the task/activity are not available or cannot be learned or if the patient's safety is a concern.	I	C

AHA/ASA GUIDELINES – ΒΟΗΘΗΤΙΚΑ ΜΕΣΑ



ΑΗΑ/ΑΣΑ GUIDELINES – ΟΣΤΕΟΠΩΡΩΣΗ

- Αφορά κυρίως την ημιπληγική πλευρά του σώματος, μη περιπατητικούς ασθενείς και γυναίκες πάνω από τα 65 έτη
- Αξιολόγηση Ca και βιταμίνης D.

Recommendations: Poststroke Osteoporosis	Class	Level of Evidence
It is recommended that individuals with stroke residing in long-term care facilities be evaluated for calcium and vitamin D supplementation.	I	A
It is recommended that US Preventive Services Task Force osteoporosis screening recommendations be followed in women with stroke.	I	B
Increased levels of physical activity are probably indicated to reduce the risk and severity of poststroke osteoporosis.	IIa	B

ΑΗΑ/ΑΣΑ GUIDELINES – ΠΟΝΟΣ ΗΜΙΠΛΗΓΙΚΟΥ ΩΜΟΥ

- 5% με 85%
- Εξάρθρωση και μυϊκή αδυναμία
- Υπερηχογραφικά ευρήματα
- Συχνά αναφέρεται και ως νευροπαθητικός
- Ενημέρωση και εκπαίδευση ασθενή και συγγενών για την σωστή θέση του μέλους
- Όχι τροχαλία σε μεγάλα εύρη.

Recommendations: Assessment, Prevention, and Treatment of Hemiplegic Shoulder Pain	Class	Level of Evidence
Patient and family education (i.e., range of motion, positioning) is recommended for shoulder pain and shoulder care after stroke, particularly before discharge or transitions in care.	I	C
Botulinum toxin injection can be useful to reduce severe hypertonicity in hemiplegic shoulder muscles.	IIa	A
A trial of neuromodulating pain medications is reasonable for patients with hemiplegic shoulder pain who have clinical signs and symptoms of neuropathic pain manifested as sensory change in the shoulder region, allodynia, or hyperpathia.	IIa	A
It is reasonable to consider positioning and use of supportive devices and slings for shoulder subluxation.	IIa	C
A clinical assessment can be useful, including:		
Musculoskeletal evaluation	IIa	C
Evaluation of spasticity	IIa	C
Identification of any subluxation	IIa	C
Testing for regional sensory changes	IIa	C
NMES may be considered (surface or intramuscular) for shoulder pain.	IIb	A
Ultrasound may be considered as a diagnostic tool for shoulder soft tissue injury.	IIb	B
Usefulness of acupuncture as an adjunct treatment for hemiplegic shoulder pain is of uncertain value.	IIb	B
Usefulness of subacromial or glenohumeral corticosteroid injection for patients with inflammation in these locations is not well established.	IIb	B
Suprascapular nerve block may be considered as an adjunctive treatment for hemiplegic shoulder pain.	IIb	B
Surgical tenotomy of pectoralis major, latissimus dorsi, teres major, or subscapularis may be considered for patients with severe hemiplegia and restrictions in shoulder range of motion.	IIb	C
The use of overhead pulley exercises is not recommended.	III	C

ΑΗΑ/ΑΣΑ GUIDELINES – ΠΟΝΟΣ ΗΜΙΠΛΗΓΙΚΟΥ ΩΜΟΥ

Lying on Hemiplegic Side



- Hemiplegic arm forward at the shoulder; elbow extended and hand supported with the palm up
- Unaffected arm supported forward on the pillow
- Pillow behind back
- Both legs bent at the hips and knees; pillow in between

Lying on Unaffected Side



- Hemiplegic arm supported forward on two pillows
- Pillow behind back
- Both legs bent at the hips and knees, a pillow in between

Sitting in Bed

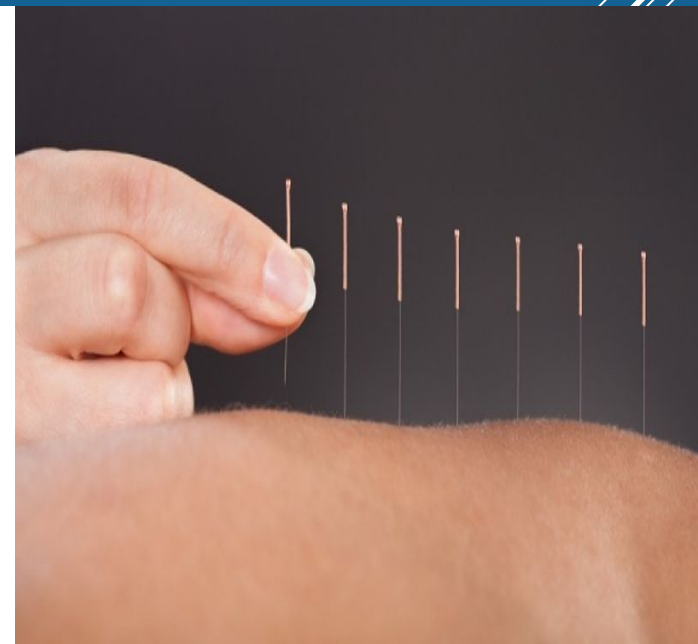
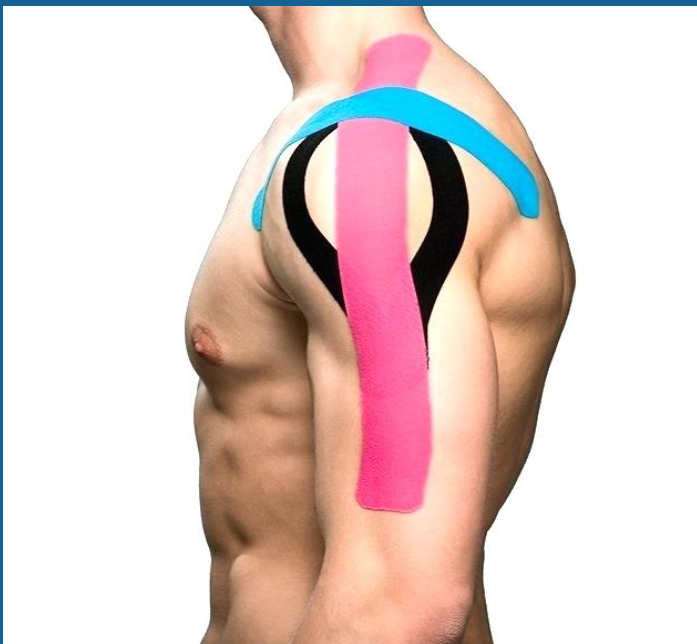


- Hemiplegic arm supported on two pillows
- Trunk in midline
- Pillows under unaffected arm as required

Sitting in Wheelchair



- Lap tray on wheelchair
- Pillow under hemiplegic arm with shoulder abducted, forearm pointing forward and hand supported



ΑΗΑ/ΑΣΑ GUIDELINES – ΠΟΝΟΣ ΚΕΝΤΡΙΚΟΥ ΤΥΠΟΥ

- 7% με 8%
- Βλάβη στο σωματοαισθητικό σύστημα
- Εξατομικευμένη φαρμακευτική θεραπεία σε συνδυασμό με διεπιστημονική παρέμβαση
- Δεν προτείνεται η χρήση TENS και εν τω βάθει ηλεκτρικός ερεθισμός εγκεφάλου

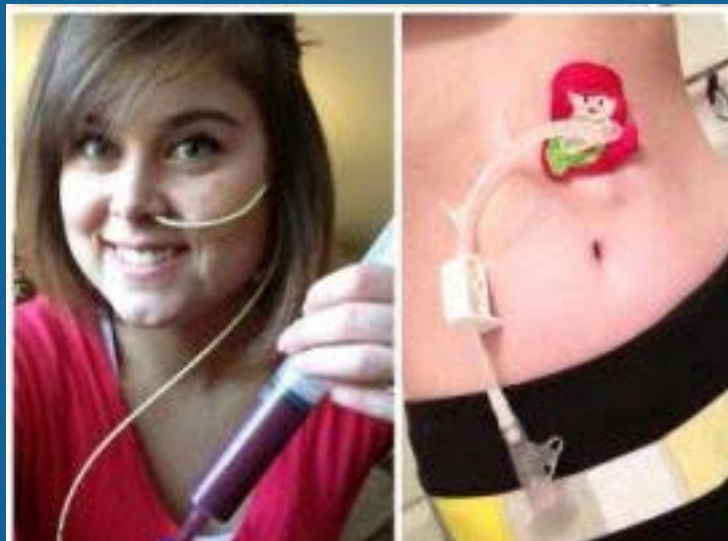
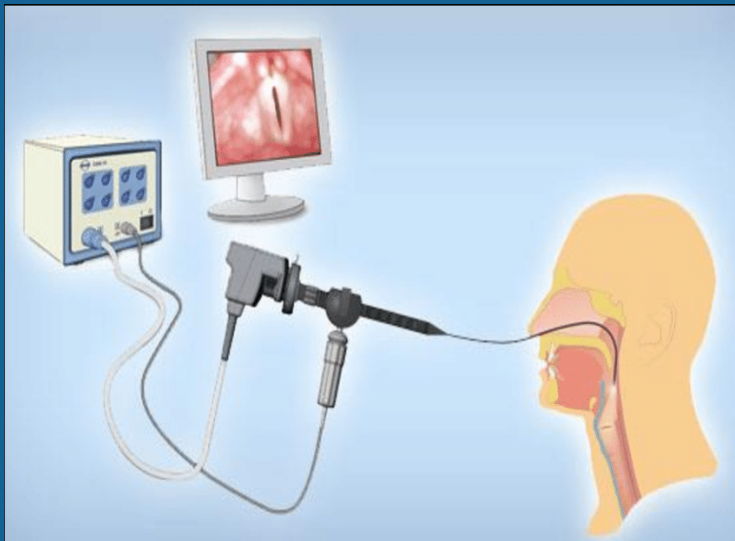
Recommendations: Central Pain After Stroke	Class	Level of Evidence
The diagnosis of central poststroke pain should be based on established diagnostic criteria after other causes of pain have been excluded.	I	C
The choice of pharmacological agent for the treatment of central poststroke pain should be individualized to the patient's needs and response to therapy and any side effects.	I	C
Amitriptyline and lamotrigine are reasonable first-line pharmacological treatments.	IIa	B
Interprofessional pain management is probably useful in conjunction with pharmacotherapy.	IIa	C
Standardized measures may be useful to monitor response to treatment.	IIb	C
Pregabalin, gabapentin, carbamazepine, or phenytoin may be considered as second-line treatments.	IIb	B
TENS has not been established as an effective treatment.	III	B
Motor cortex stimulation might be reasonable for the treatment of intractable central poststroke pain that is not responsive to other treatments in carefully selected patients.	IIb	B
Deep brain stimulation has not been established as an effective treatment.	III	B

ΑΗΑ/ΑΣΑ GUIDELINES – ΔΥΣΦΑΓΙΑ

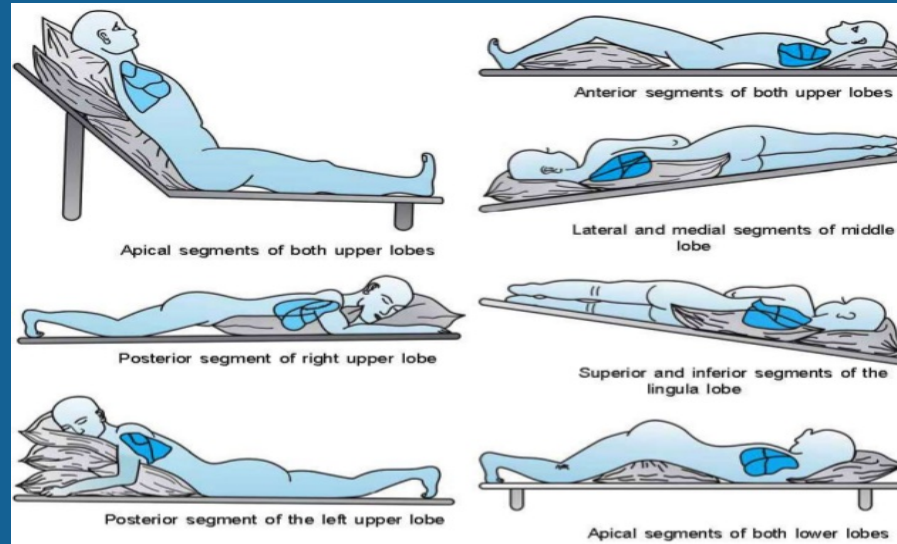
- 42% με 67% μετά από ΑΕΕ, το 1/3 θα εισροφήσει, το 1/2 θα εμφανίσει λοίμωξη του αναπνευστικού.
- Πρώιμη αξιολόγηση και αντιμετώπιση με ή χωρίς απεικονιστικές μεθόδους.
- Στοματική υγιεινή, άμεση σίτιση με σωλήνα Levin ή γαστροστομία εντός 3 εβδομάδων.

Recommendations: Dysphagia Screening, Management, and Nutritional Support	Class	Level of Evidence
Early dysphagia screening is recommended for acute stroke patients to identify dysphagia or aspiration, which can lead to pneumonia, malnutrition, dehydration, and other complications.	I	B
Dysphagia screening is reasonable by a speech-language pathologist or other trained healthcare provider.	IIa	C
Assessment of swallowing before the patient begins eating, drinking, or receiving oral medications is recommended.	I	B
An instrumental evaluation is probably indicated for those patients suspected of aspiration to verify the presence/absence of aspiration and to determine the physiological reasons for the dysphagia to guide the treatment plan.	IIa	B
Selection of instrumental study (fiberoptic endoscopic evaluation of swallowing, videofluoroscopy, fiberoptic endoscopic evaluation of swallowing with sensory testing) may be based on availability or other considerations.	IIb	C
Oral hygiene protocols should be implemented to reduce the risk of aspiration pneumonia after stroke.	I	B
Enteral feedings (tube feedings) should be initiated within 7 days after stroke for patients who cannot safely swallow.	I	A
Nasogastric tube feeding should be used for short term (2–3 weeks) nutritional support for patients who cannot swallow safely.	I	B
Percutaneous gastrostomy tubes should be placed in patients with chronic inability to swallow safely.	I	B
Nutritional supplements are reasonable to consider for patients who are malnourished or at risk of malnourishment.	IIa	B
Incorporating principles of neuroplasticity into dysphagia rehabilitation strategies/interventions is reasonable.	IIa	C
Behavioral interventions may be considered as a component of dysphagia treatment.	IIb	A
Acupuncture may be considered as an adjunctive treatment for dysphagia.	IIb	B
Drug therapy, NMES, pharyngeal electrical stimulation, physical stimulation, tDCS, and transcranial magnetic stimulation are of uncertain benefit and not currently recommended.	III	A

ΑΗΑ/ΑΣΑ GUIDELINES – ΔΥΣΦΑΓΙΑ



ΑΗΑ/ΑΣΑ GUIDELINES – ΔΥΣΦΑΓΙΑ



- Αναπνευστική φυσικοθεραπεία σε περίπτωση λοίμωξης λόγω εισρόφησης



ΑΗΑ/ΑΣΑ GUIDELINES – ΨΥΧΟΛΟΓΙΚΕΣ ΔΙΑΤΑΡΑΧΕΣ

- 13% με 33% κατάθλιψη μετά από ΑΕΕ
- Αρνητική επίδραση στην αποκατάσταση
- Πρώιμη αξιολόγηση, ενημέρωση και παρέμβαση (Beck Depression Inventory, Patient Health Questionnaire)
- Εξατομικευμένη φαρμακευτική αγωγή κι ψυχοθεραπεία.

Recommendations: Poststroke Depression, Including Emotional and Behavioral State	Class	Level of Evidence
Administration of a structured depression inventory such as the Patient Health Questionnaire-2 is recommended to routinely screen for poststroke depression.	I	B
Patient education about stroke is recommended. Patients should be provided with information, advice, and the opportunity to talk about the impact of the illness on their lives.	I	B
Patients diagnosed with poststroke depression should be treated with antidepressants in the absence of contraindications and closely monitored to verify effectiveness.	I	B
A therapeutic trial of an SSRI or dextromethorphan/quinidine is reasonable for patients with emotional lability or pseudobulbar affect causing emotional distress.	IIa	A
Periodic reassessment of depression, anxiety, and other psychiatric symptoms may be useful in the care of stroke survivors.	IIa	B
Consultation by a qualified psychiatrist or psychologist for stroke survivors with mood disorders causing persistent distress or worsening disability can be useful.	IIa	C
The usefulness of routine use of prophylactic antidepressant medications is unclear.	IIb	A
Combining pharmacological and nonpharmacological treatments of poststroke depression may be considered.	IIb	A
The efficacy of individual psychotherapy alone in the treatment of poststroke depression is unclear.	IIb	B
Patient education, counseling, and social support may be considered as components of treatment for poststroke depression.	IIb	B
An exercise program of at least 4 weeks duration may be considered as a complementary treatment for poststroke depression.	IIb	B
Early effective treatment of depression may have a positive effect on the rehabilitation outcome.	IIb	B
No recommendation for the use of any particular class of antidepressants is made. SSRIs are commonly used and generally well tolerated in this patient population.	III	A

ΑΗΑ/ΑΣΑ GUIDELINES – ΨΥΧΟΛΟΓΙΚΕΣ ΔΙΑΤΑΡΑΧΕΣ



ΑΗΑ/ΑΣΑ GUIDELINES- ΠΡΟΛΗΨΗ ΕΝ ΤΩ ΒΑΘΕΙ ΦΛΕΒΟΘΡΟΜΒΩΣΗΣ

- Χορήγηση ηπαρίνης χαμηλού μοριακού βάρους vs μη κλασματοποιημένης ηπαρίνης
- Χρήση συσκευής ασκών πίεσης-αποσυμπίεσης
- Δεν ενδείκνυται η χρήση ελαστικών καλτσών

Recommendations: Prevention of DVT	Class	Level of Evidence
In ischemic stroke, prophylactic-dose subcutaneous heparin (UFH or LMWH) should be used for the duration of the acute and rehabilitation hospital stay or until the stroke survivor regains mobility.	I	A
In ischemic stroke, it is reasonable to use prophylactic-dose LMWH over prophylactic-dose UFH for prevention of DVT.	IIa	A
In ischemic stroke, it may be reasonable to use intermittent pneumatic compression over no prophylaxis during the acute hospitalization.	IIb	B
In ICH, it may be reasonable to use prophylactic-dose subcutaneous heparin (UFH or LMWH) started between days 2 and 4 over no prophylaxis.	IIb	C
In ICH, it may be reasonable to use prophylactic-dose LMWH over prophylactic-dose UFH.	IIb	C
In ICH, it may be reasonable to use intermittent pneumatic compression devices over no prophylaxis.	IIb	C
In ischemic stroke, it is not useful to use elastic compression stockings.	III	B
In ICH, it is not useful to use elastic compression stockings.	III	C

ΑΗΑ/ΑSΑ GUIDELINES- ΠΡΟΛΗΨΗ ΕΝ ΤΩ ΒΑΘΕΙ ΦΛΕΒΟΘΡΟΜΒΩΣΗΣ

UFH



LMWH



VS



ΑΗΑ/ΑΣΑ GUIDELINES – ΔΙΑΤΑΡΑΧΕΣ ΟΥΡΟΔΟΧΟΥ ΚΥΣΤΗΣ ΚΑΙ ΕΝΤΕΡΟΥ

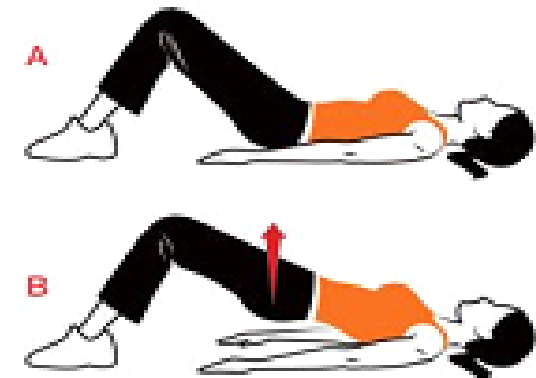
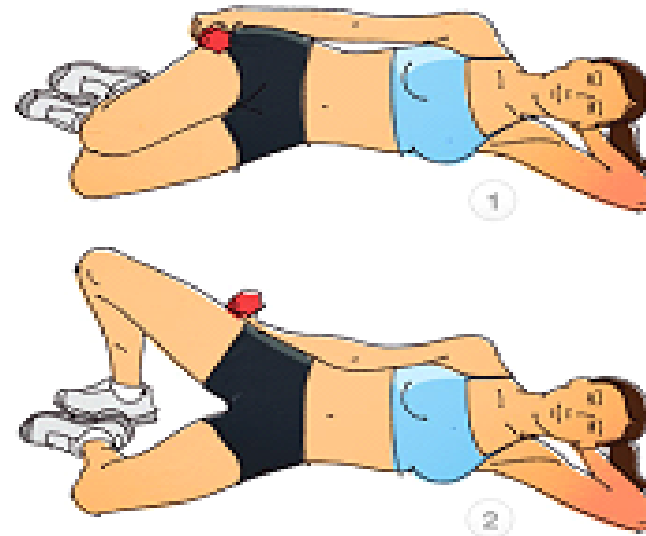
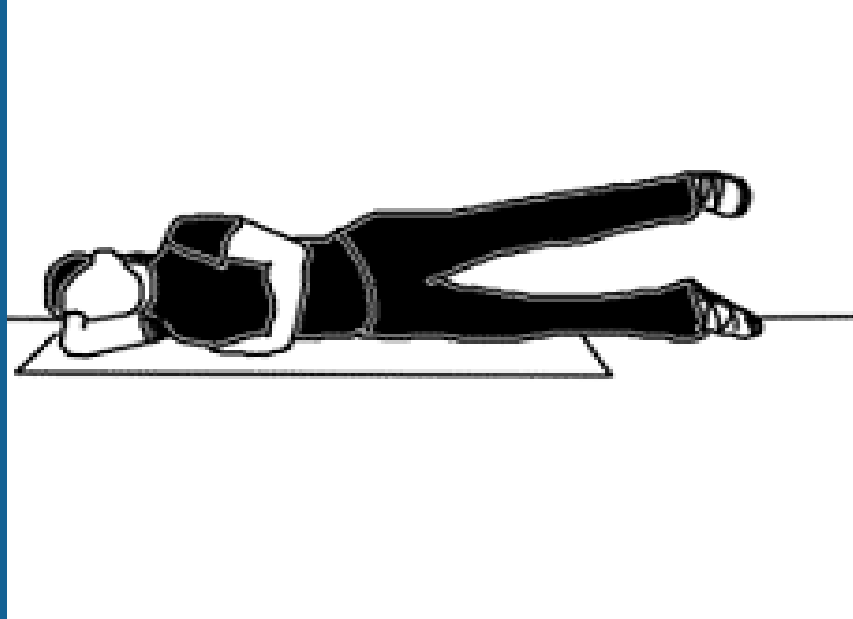
- 40% με 60% κατά την εισαγωγή
- Χρήση υπερήχου και διαλείποντος καθετηριασμού
- Αφαίρεση καθετήρα εντός 24 ωρών.

Recommendations: Treatment of Bowel and Bladder Incontinence	Class	Level of Evidence
Assessment of bladder function in acutely hospitalized stroke patients is recommended.		
A history of urological issues before stroke should be obtained.	I	B
Assessment of urinary retention through bladder scanning or intermittent catheterizations after voiding while recording volumes is recommended for patients with urinary incontinence or retention.	I	B
Assessment of cognitive awareness of need to void or having voided is reasonable.	IIa	B
Removal of the Foley catheter (if any) within 24 hours after admission for acute stroke is recommended.	I	B
It is reasonable to use the following treatment interventions to improve bladder incontinence in stroke patients:	IIa	B
Prompted voiding		
Pelvic floor muscle training (after discharge home)		
It may be reasonable to assess prior bowel function in acutely hospitalized stroke patients and include the following:	IIb	C
Stool consistency, frequency, and timing (before stroke)		
Bowel care practices before stroke		

ΑΗΑ/ASA GUIDELINES – ΔΙΑΤΑΡΑΧΕΣ ΟΥΡΟΔΟΧΟΥ ΚΥΣΤΗΣ ΚΑΙ ΕΝΤΕΡΟΥ



Intermittent Urinary Catheters



ΑΗΑ/ΑΣΑ GUIDELINES – ΓΝΩΣΙΑΚΑ ΕΛΛΕΙΜΜΑΤΑ

- Αφορά προβλήματα όπως: οπτική και εγκεφαλική μνήμη, εκτέλεση και ταχύτητα απλών ή σύνθετων πράξεων, προσοχή, αντίληψη, ομιλία.
- Εμπλουτισμός περιβάλλοντος με πολλαπλά ερεθίσματα
- Γνωσιακή αποκατάσταση
- Μουσική, άσκηση και εργαλεία εικονική πραγματικότητας

Recommendations: Nondrug Therapies for Cognitive Impairment, Including Memory	Class	Level of Evidence
Enriched environments to increase engagement with cognitive activities are recommended.	I	A
Use of cognitive rehabilitation to improve attention, memory, visual neglect, and executive functioning is reasonable.	IIa	B
Use of cognitive training strategies that consider practice, compensation, and adaptive techniques for increasing independence is reasonable.	IIa	B
Compensatory strategies may be considered to improve memory functions, including the use of internalized strategies (eg, visual imagery, semantic organization, spaced practice) and external memory assistive technology (eg, notebooks, paging systems, computers, other prompting devices).	IIb	A
Some type of specific memory training is reasonable such as promoting global processing in visual-spatial memory and constructing a semantic framework for language-based memory.	IIb	B
Errorless learning techniques may be effective for individuals with severe memory impairments for learning specific skills or knowledge, although there is limited transfer to novel tasks or reduction in overall functional memory problems.	IIb	B
Music therapy may be reasonable for improving verbal memory.	IIb	B
Exercise may be considered as adjunctive therapy to improve cognition and memory after stroke.	IIb	C
Virtual reality training may be considered for verbal, visual, and spatial learning, but its efficacy is not well established.	IIb	C
Anodal tDCS over the left dorsolateral prefrontal cortex to improve language-based complex attention (working memory) remains experimental.	III	B

ΑΗΑ/ΑΣΑ GUIDELINES – ΣΥΝΔΡΟΜΟ ΜΟΝΟΜΕΛΟΥΣ ΠΑΡΑΜΕΛΗΣΗΣ ΚΑΙ ΑΠΡΑΞΙΑ ΜΕΛΟΥΣ

- Αφορά κυρίως την αριστερή πλευρά .
- Εξειδικευμένες παρεμβάσεις από ειδικούς.
- Διακρανιακός μαγνητικός ερεθισμός



Recommendations: Hemispatial Neglect or Hemi-Inattention	Class	Level of Evidence
It is reasonable to provide repeated top-down and bottom-up interventions such as prism adaptation, visual scanning training, optokinetic stimulation, virtual reality, limb activation, mental imagery, and <u>neck vibration</u> combined with prism adaptation to improve neglect symptoms.	IIa	A
Right visual field testing may be considered.	IIb	B
<u>Benefitive transcranial magnetic stimulation</u> of various forms may be considered to ameliorate neglect symptoms.	IIb	B

Recommendations: Limb Apraxia	Class	Level of Evidence
Strategy training or gesture training for apraxia may be considered.	IIb	B
Task practice for apraxia with and without mental rehearsal may be considered.	IIb	C

ΑΗΑ/ΑSΑ GUIDELINES – ΠΡΟΛΗΨΗ ΕΠΙΛΗΠΤΙΚΩΝ ΚΡΙΣΕΩΝ

- Πρώιμη κρίση 2% με 23%
- Όψιμη κρίση 3% με 67%
- Όχι σε θεραπεία ρουτίνας
- Παρουσία σε οποιαδήποτε φάση της αποκατάστασης

Recommendations: Seizures	Class	Level of Evidence
Any patient who develops a seizure should be treated with standard management approaches, including a search for reversible causes of seizure in addition to potential use of antiepileptic drugs.	I	C
Routine seizure prophylaxis for patients with ischemic or hemorrhagic stroke is not recommended.	III	C

ΑΗΑ/ΑΣΑ GUIDELINES – ΔΙΑΤΑΡΑΧΕΣ ΛΟΓΟΥ

- Αφασία και δυσαρθρία
- Παρέμβαση λογοθεραπευτή, εκπαίδευση συγγενών και φροντιστών
- Χρήση βοηθητικών και εναλλακτικών συσκευών και τεχνολογιών

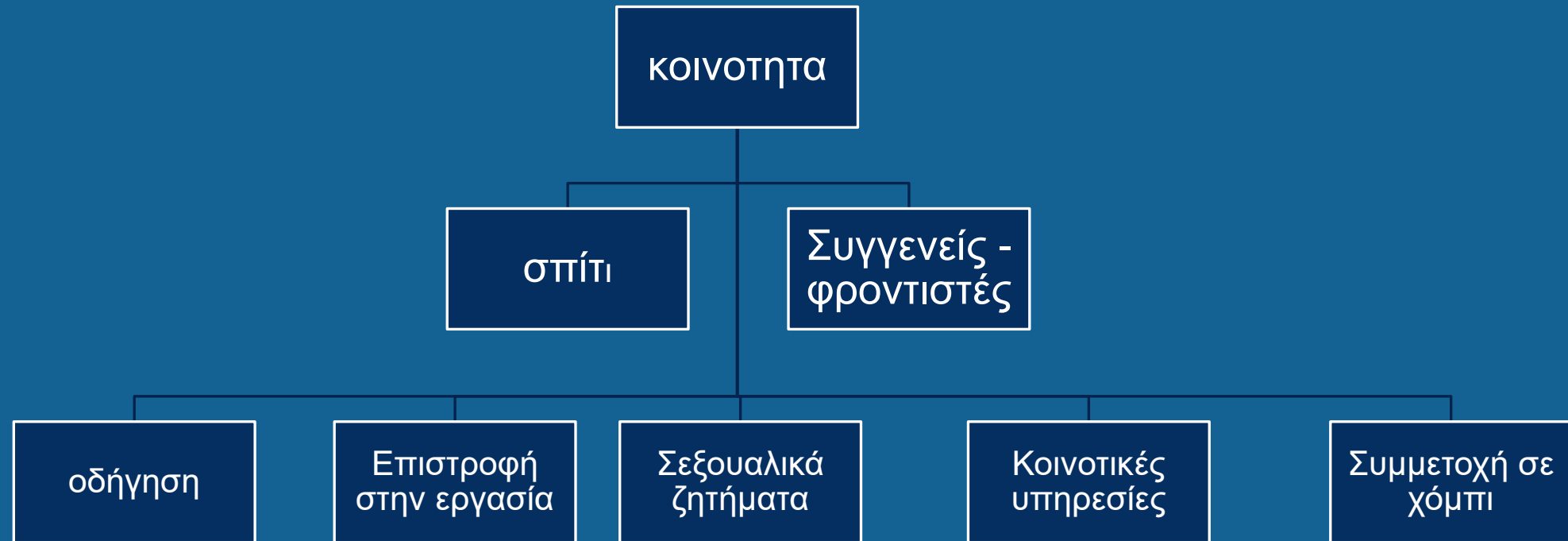
Recommendations: Aphasia	Class	Level of Evidence
Speech and language therapy is recommended for individuals with aphasia.	I	A
Treatment for aphasia should include communication partner training.	I	B
Intensive treatment is probably indicated, but there is no definitive agreement on the optimum amount, timing, intensity, distribution, or duration of treatment.	IIa	A
Computerized treatment may be considered to supplement treatment provided by a speech-language pathologist.	IIb	A
A variety of different treatment approaches for aphasia may be useful, but their relative effectiveness is not known.	IIb	B
Group treatment may be useful across the continuum of care, including the use of community-based aphasia groups.	IIb	B
Pharmacotherapy for aphasia may be considered on a case-by-case basis in conjunction with speech and language therapy, but no specific regimen is recommended for routine use at this time.	IIb	B
Brain stimulation techniques as adjuncts to behavioral speech and language therapy are considered experimental and therefore are not currently recommended for routine use.	III	B
Recommendations: Motor Speech Disorders: Dysarthria and Apraxia of Speech	Class	Level of Evidence
Interventions for motor speech disorders should be individually tailored and can include behavioral techniques and strategies that target:	I	B
Physiological support for speech, including respiration, phonation, articulation, and resonance		
Global aspects of speech production such as loudness, rate, and prosody		
Augmentative and alternative communication devices and modalities should be used to supplement speech.	I	C
Telerehabilitation may be useful when face-to-face treatment is impossible or impractical.	IIa	C
Environmental modifications, including listener education, may be considered to improve communication effectiveness.	IIb	C
Activities to facilitate social participation and promote psychosocial well-being may be considered.	IIb	C

ΑΗΑ/ΑΣΑ GUIDELINES – ΦΥΣΙΚΗ ΚΑΤΑΣΤΑΣΗ ΜΕΤΑ ΤΟ ΑΕΕ

- 30% πιθανότητα για 2^ο ΑΕΕ.
- Διατήρηση ενεργητικότητας μέσα από προγράμματα αερόβιας άσκησης μετά από έλεγχο της υγείας.
- Ελαχιστοποίηση παραγόντων κινδύνου Καρδιαγγειακής Νόσου.

Recommendations: Chronic Care Management: Home- and Community-Based Participation	Class	Level of Evidence
After successful screening, an individually tailored exercise program is indicated to enhance cardiorespiratory fitness and to reduce the risk of stroke recurrence.	I	A (for improved fitness); B (for reduction of stroke risk)
After completion of formal stroke rehabilitation, participation in a program of exercise or physical activity at home or in the community is recommended.	I	A

ΑΗΑ/ΑΣΑ GUIDELINES – ΜΕΤΑΒΑΣΗ ΣΤΗΝ ΚΟΙΝΟΤΗΤΑ



AHA/ASA GUIDELINES – ΜΕΤΑΒΑΣΗ ΣΤΗΝ ΚΟΙΝΟΤΗΤΑ

Recommendations: Referral to Community Resources	Class	Level of Evidence
It is recommended that acute care hospitals and rehabilitation facilities maintain up-to-date inventories of community resources.	I	C
Patient and family/caregiver preferences for resources should be considered.	I	C
It is recommended that information about local resources be provided to the patient and family.	I	C
It is recommended that contact with community resources be offered through formal or informal referral.	I	C
Follow-up is recommended to ensure that the patient and family receive the necessary services.	I	C

Recommendations: Social and Family Caregiver Support	Class	Level of Evidence
It may be useful for the family/caregiver to be an integral component of stroke rehabilitation.	IIb	A
It may be reasonable that family/caregiver support include some or all of the following on a regular basis:	IIb	A
Education		
Training		
Counseling		
Development of a support structure		
Financial assistance		
It may be useful to have the family/caregiver involved in decision making and treatment planning as early as possible and throughout the duration of the rehabilitation process.	IIb	B

AHA/ASA GUIDELINES – ΜΕΤΑΒΑΣΗ ΣΤΗΝ ΚΟΙΝΟΤΗΤΑ

Recommendations: Return to Driving	Class	Level of Evidence
Individuals who appear to be ready to return to driving, as demonstrated by successful performance on fitness-to-drive tests, should have an on-the-road test administered by an authorized person.	I	C
It is reasonable that individuals be assessed for cognitive, perception, physical, and motor abilities to ascertain readiness to return to driving according to safety and local laws.	IIa	B
It is reasonable that individuals who do not pass an on-the-road driving test be referred to a driver rehabilitation program for training.	IIa	B
A driving simulation assessment may be considered for predicting fitness to drive.	IIb	C

Recommendations: Recreational and Leisure Activity	Class	Level of Evidence
It is reasonable to promote engagement in leisure and recreational pursuits, particularly through the provision of information on the importance of maintaining an active and healthy lifestyle.	IIa	B
It is reasonable to foster the development of self-management skills for problem solving for overcoming barriers to engagement in active activities.	IIa	B
It is reasonable to start education and self-management skill development about leisure/recreation activities during and in conjunction with in-patient rehabilitation.	IIa	B
Recommendation: Sexual Function	Class	Level of Evidence
An offer to patients and their partners to discuss sexual issues may be useful before discharge home and again after transition to the community. Discussion topics may include safety concerns, changes in libido, physical limitations resulting from stroke, and emotional consequences of stroke.	IIb	B

AHA/ASA GUIDELINES – ΜΕΤΑΒΑΣΗ ΣΤΗΝ ΚΟΙΝΟΤΗΤΑ

Recommendations: Rehabilitation in the Community	Class	Level of Evidence
Patients with stroke receiving comprehensive ADL, IADL, and mobility assessments, including evaluation of the discharge living setting, should be considered candidates for community- or home-based rehabilitation when feasible. Exclusions include individuals with stroke who require daily nursing services, regular medical interventions, specialized equipment, or interprofessional expertise.	I	A
It is reasonable that caregivers, including family members, be involved in training and education related directly to home-based rehabilitation programs and be included as active partners in the planning and implementation of treatment activities under the supervision of professionals.	IIa	B
A formal plan for monitoring compliance and participation in treatment activities may be useful for individuals with stroke referred for home- or community-based rehabilitation services. A case manager or professional staff person should be assigned to oversee implementation of the plan.	IIb	B

Recommendations: Return to Work	Class	Level of Evidence
Vocationally targeted therapy or vocational rehabilitation is reasonable for individuals with stroke considering a return to work.	IIa	C
An assessment of cognitive, perception, physical, and motor abilities may be considered for stroke survivors considering a return to work.	IIb	C

Recommendation: Ensuring Medical and Rehabilitation Continuity Through the Rehabilitation Process and Into the Community	Class	Level of Evidence
It is reasonable to consider individualized discharge planning in the transition from hospital to home.	IIa	B
It is reasonable to consider alternative methods of communication and support (eg, telephone visits, telehealth, or Web-based support), particularly for patients in rural settings.	IIa	B

ΣΥΜΠΕΡΑΣΜΑΤΑ

- Συνεχής διεπιστημονική συνεργασία και συντονισμός παρεμβάσεων
- Παρεμβάσεις που στηρίζονται σε μεγάλο αριθμό Τυχαιοποιημένων Μελετών
- Η σημασία της πρώιμης αξιολόγησης – παρέμβασης από τα μέλη της διεπιστημονικής ομάδας
- Η σημασία της άσκησης σε όλα τα επίπεδα της αποκατάστασης
- Κατανόηση της νοοτροπίας αντιμετώπισης του ΑΕΕ ως χρόνιου περιστατικού.
- Κενά υπάρχουν, χρειάζεται: - έρευνα σε πολύπλευρες παρεμβάσεις
 - έρευνα για τη χρήση της τεχνολογίας, των μέσων εικονικής πραγματικότητας και των μέσων μαζικής δικτύωσης
 - έρευνα στην ανάπτυξη εξατομικευμένων παρεμβάσεων και καλύτερων προγνωστικών μοντέλων