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2017

Editorial Stroke

Christine NG, Heather CHU and Wendy CHIANG

Stroke, also known as cerebrovascular accident (CVA) is the third leading cause of death in Hong Kong after cancer and ischaemic heart disease and around twenty-five thousand stroke patients admitted into public hospitals annually (Hospital Authority, 2015). Although medical advances have decreased the mortality of stroke patients, the impacts on both the survivors and community are still great and urge better plan of rehabilitation.

In this issue, we are delighted to have Dr. Ismail and Dr. Fong from the Queen Elizabeth Hospital sharing their viewpoints on timely physiotherapy interventions and formulating an effective training protocol for acute stroke patients. Whilst stroke patient's recovery and quality of life depends on long-term rehabilitation after being discharged from hospital, two service models in community settings (1) Tung Wah Group of Hospitals Community Service - Lok Kwan Home Care Service, and (2) Buddhist Li Ka Shing Care and Attention Home for the Elderly will be shared by expertise in community physiotherapy.

In Legal Column, our Honorary Legal Advisor, Mr. Bronco But will advise you how to avoid the risk of contravening the Code of Practice before you are going to print your business card – check out the list of Quotable Qualifications!

Early Mobilization after Acute Stroke - a Hot Debate

Dr. Ismail M, MRCP, Resident Specialist; **Dr. FONG WC**, FRCP, Consultant
Department of Medicine, Queen Elizabeth Hospital

Rehabilitation is the cornerstone of integrative stroke management. However, very early mobilization after stroke, as defined by out-of-bed interventions starting in the first 24 to 72 hours after stroke^[1], remains controversial.

There are several rationales to support early mobilization. First, bed rest is potentially harmful. From a systematic review, bed rest is associated with more disability, venous thrombosis, and a longer time for recovery in patients with acute low back pain, uncomplicated myocardial infarction and acute infectious hepatitis respectively^[2]. Even in healthy elderly, bed rest can reduce muscle protein synthesis and muscle strength^[3]. Moreover, animal study showed that enriched rehabilitation initiated earlier after stroke provided substantial functional benefit and improved structural plasticity^[4]. Thus, it is logical to initiate rehabilitation as early as possible.

On the other hand, early mobilization may also be harmful. In animal study, hyperglycosis, which can lead to apoptotic cell death, was seen in rats that exercise 6 hours but not 3 days after stroke^[5]. Besides, mobilization may lead to high blood pressure, which was shown to be associated with a poorer functional outcome in patients with intracerebral haemorrhage^[6]. In addition, patients with poor capacity of cerebral auto regulation due to large vessel occlusion, neurological symptoms may be provoked by standing up and exercise^[7]. It is, therefore, reasonable to be cautious when mobilizing patients after acute stroke.

Numerous attempts have been made to establish the evidence supporting early mobilization after acute stroke. A systematic review and meta-analysis by Lynch and colleagues^[8], which included three randomized control trials with 159 patients in total, showed unclear benefit of early rehabilitation within 24 hours of stroke onset in improving mortality and functional outcome at 3 months. This may be related to the substantial heterogeneity among the three studies. The study that have the worst functional outcome after early mobilization recruited highest proportion of patients with intracerebral haemorrhage (21.7%)^[9], while that of the best outcome has the lowest (0.03%)^[10].

In view of the uncertain benefit of early mobilization after acute stroke, an international multi-center randomized control trial (AVERT) was performed^[11]. It recruited 2,104 patients with ischemic stroke or intra-cerebral hemorrhaged admitted within 24 hours of stroke onset. 45% of subjects had admission NIHSS 8 or above indicating moderate to severe stroke, 24% had received recombinant tissue plasminogen activator treatment and 12% had intra-cerebral hemorrhaged. Patients with unstable hemodynamics status or not responding to voice were excluded. The subjects were randomized in the very early mobilization (VEM) group and usual care group. Those in the VEM group received at least three out-of-bed sessions within 24 hours of stroke onset. The sessions included sitting, standing and or walking for 14 days or until discharged from stroke unit, whichever was earlier. A pre-defined protocol was used to titrate the rehabilitation program depending on the functional ability of the patient. The median time to first mobilization in the VEM group was 18.5 hours (interquartile range [IQR] 12.8-22.3). Compare to the usual care group, mobilization of the VEM group started on average 4.8 hours earlier, lasted longer and was performed more frequently.

However, contrary to the great anticipation, the result of AVERT was disappointing. Significantly fewer patients in the VEM group have a favorable outcome (modified Rankin scale [mRS] 0-2) 3 months after stroke (adjusted odds ratio [OR] 0.73, 95% Confidence interval [CI] 0.59-0.90; $p=0.004$). There were no differences in the length of hospital stay and frequency of immobility adverse events between the two groups. In subgroup analysis, a further reduced odds of favorable outcome at three months was observed in VEM patients suffering from intra-cerebral hemorrhaged (OR 0.48, 95% CI 0.25-0.92) or severe stroke (OR 0.35, 95% CI 0.11-1.18), while the use of recombinant tissue plasminogen activator did not make a difference^[12]. What are the possible explanations to this surprising result?

One of the reasons is that the usual care group started training only slightly later than the VEM group. The median time to first mobilization in the usual care group was 22.4 hours (IQR 16.5-29.3), which was still within the 24-hour time frame. Therefore, the potential harm of delay mobilization cannot be demonstrated. Indeed, another

(Continued on Page 3)

smaller randomized control trial consisted of 86 acute stroke patient showed that those receiving VEM according to AVERT protocol have significant improvement in the change in Barthel index upon discharge as well as functional outcome at 3 months follow up^[13]. In that trial, the median time to first mobilization in the VEM group was 18 hours (IQR 16.62-19.75) while that of the standard care group was 30.5 hours (IQR 29-35). Furthermore, apart from mobilizing earlier, the patients in VEM group in AVERT also received more intensive training. The effect of early mobilization alone on the odds on favorable outcome was not analyzed.

In view of this, the authors carried out a dose response analysis of the AVERT database to find out the optimal timing and frequency of mobilization after acute stroke^[14]. It showed that longer time from stroke onset to first mobilization out of bed is associated with lower odds of favorable outcome (mRS 0-2) after adjusting for age, stroke severity, and the frequency and daily amount of out-of-bed activities (OR 0.99 per one hour delay, 95% CI 0.98-1.0, $p = 0.036$). Besides, increase in the frequency of out-of-bed activities improved the odds of favorable outcome (OR 1.13 per one extra daily session, 95% CI 1.09-1.18, $p < 0.001$). On the contrary, increase in the time of out-of-bed activities per day or in total reduced the odds of favorable outcome, if the frequency of session and time to first mobilization remained constant. Similar effects of these parameters on the time to unassisted walking for 50 meters were also seen. In line with this finding, a retrospective cohort in Japan also showed that acute stroke patients receiving 7 days rehabilitation have better functional outcome compared to those received 5-6 days of training per week^[15]. Although the result is only applicable to training within 14 days of stroke onset, and the optimal frequency and timing of training are still unknown, AVERT has demonstrated that short and frequent mobilization sessions starting earlier may be beneficial to patients with acute stroke.

Stroke rehabilitation is far too complex and individualized than a one-size-fits-all protocol. Nevertheless, AVERT showed us that optimal physical training in the acute phase of stroke can exert a positive impact on long-term functional outcome. More importantly, it revealed that timing and frequency of physical activity are perhaps more important than the total amount of exercise. From practical point of view, this valuable evidence has highlighted the paramount importance of early input by physiotherapists in patients with acute stroke. Clinician should therefore collaborate with physiotherapists to formulate the most effective training protocol by splitting the usual once daily session into several shorter sessions per day to enhance the favorable effect of early rehabilitation.

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Stroke Rehabilitation in the Community

Mr. Tony WONG

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Introduction

According to the World Health Organization, there are more than 15 million new stroke patients every year^[1]; and someone in the world suffers from a stroke in every two seconds. Nearly six million people die and another five million are left permanently disabled. In Hong Kong, cerebrovascular diseases ranked the third leading cause of death in 2015^[2]. It is estimated that 18500 people suffer from a new or recurrent stroke in Hong Kong^[3] and one in six men may suffer a stroke every year^[4]. The word "stroke" indicates that no one is ever prepared for this sudden catastrophic event. The burden falls on the shoulders of both the victim and their carer^[1]. Being the second leading cause of long-term adult disability, it is one of the three most common causes of hospital admissions, taking up the highest number of hospital bed days and the most common condition which needs long term multi-disciplinary care, including physiotherapy^[5].

Survival rate of acute stroke depends on early stage of hospital care. However, the greatest impact on patient's recovery and quality of life depends on long-term rehabilitation after being discharged from hospital^[6]. "The objective of Hong Kong rehabilitation services is to help persons with disabilities to develop their physical, mental and social capabilities to the fullest extent which their disability permits^[7]". Maximum recovery requires provision of holistic multidisciplinary rehabilitation. Delivery of stroke specialist physiotherapy care at patient's home is increasingly common. Evidence also shows that rehabilitation in home setting is beneficial to patients reintegrating into the community^[8].

Why do we need Community Rehabilitation for Stroke Patients?

Impact on stroke survivors, their family and care-givers are devastating and multidimensional. Stroke affects functional ability, causes impairments, limits activities and decreases quality of life. In terms of disability, the most common and obvious impairment is motor-related, affecting dexterity and mobility. Stroke also affects swallowing, speech, sensation and cognitive function. Consequence of these impairments affect every single parts of their life^[6].

Furthermore, there are problems that cannot be seen directly. When damage occurs in our brain, not only are those functions which might be the primary concern of that region disturbed, the entire brain also suffers from the loss of communication with the injured part. The remaining normal portions of the brain are deprived of communication with the damaged area. This generates abnormal messages and misinformation as a result of the lesion. It affects balance, coordination, sensory perception and spatial orientation that cause disastrous effects. Memory, emotion, personality and behavior will also be altered^[9].

A recent study explored the impact of stroke from a patient's perspective, in addition to issues concerning mobility, falls, pain, and incontinence, hidden problems such as fatigue, memory, and frustration were also reported by a high proportion of respondents^[6]. Stress on carers and families can have deleterious effects on their health, which then negatively affect the recovery of stroke patients^[10].

Rehabilitation of stroke survivors is complex. Researchers usually target a specific impairment with a specific treatment. Nevertheless, goals such as increasing social participation involves a wide range of treatments and provision of complex interventions with different components^[6]. Treatment goals are tailor made in community rehabilitation to improve functional abilities and social participation. It is attributed by physical, social and environmental factors. Similar to inpatient and outpatient physiotherapy, community physiotherapy not only provides treatment such as stretching and strengthening exercises, acupuncture, muscle electrical stimulation and Kinesio taping are also used to improve functional abilities of stroke patients^[11]. With regard to physiotherapy, task-specific training for lower limbs is shown to have significant improvement in activities of daily living (measured by Barthel Index) and social participation^[6,17]. Statistically significant improvement in walking distance, walking speed and sit-to-stand stability all contribute to the improvement in functional abilities^[12]. Re-integration into society is also one of the main focuses to maximise and sustain functional returns in stroke patients. Thus, it is suggested that the rehabilitation has to take place in our community^[6]. Some reviews have

(Continued on Page 5)

investigated physiotherapy interventions addressing gait, balance, and movement. Others have evaluated the effectiveness of multidisciplinary rehabilitation services.

Multidisciplinary Stroke Teams

Langhorne reported that Home Based Rehabilitation Services provided by coordinated, multidisciplinary teams of stroke specialists can reduce length of hospital stay and increase the extend of regaining independence in active daily activities for stroke patients^[13]. International stroke rehabilitation guidelines; such as United Kingdom and Australia, also recommend home-based rehabilitation services^[14].

Many people refer the first three to six months as the golden period of stroke rehabilitation^[15]. But does it mean that stroke rehabilitation ends after six months? Clinically, different patients may experience huge difference in the rate of recovery. It mostly depends on the severity and extent of stroke, response and treatment effect on different types, modes and intensity of rehabilitation. Studies showed that stroke patients would have different degrees of recovery and progress after months, or even a few years after onset of stroke; which implies extended rehabilitation and patient care is crucial in the patient journey^[3,13,17]. Tung Wah Group of Hospitals Community Service - Lok Kwan Home Care Service is a multidisciplinary professional team aims at providing home based rehabilitation services and care for Persons with Severe Disabilities living in Hong Kong Island and Islands. We provide home-based support services to meet the needs of persons with physical or intellectual disabilities, to enable continuous rehabilitation in the community and enhance their quality of life. We also provide carer education and support to enhance their caring capability and relieve the stress of family members and care-givers. Our ultimate goal is to provide holistic rehabilitation to stroke patients so that they can regain their optimal abilities and maximize rehabilitation potential to their fullest extent.

Conclusions

Physiotherapy is proven to be both clinical-and-cost effective in treating stroke patients^[16]. Evidence shows that rehabilitation of stroke patients in the community could have continuous recovery, with regaining of independence and improve abilities to perform activities of daily living^[6,8]. Reviews also reported home-based rehabilitation is cost-effective and with good carer satisfaction score^[8,13,18]. In Hong Kong, public resources allocated to support services for persons with disabilities and elderly have increased by 50-55% in recent 4 years. To enhance and expand the community outreach healthcare services is one of the current goals of the Government^[7,19]. We hope community services will continue to enhance and strengthen so as to meet the rehabilitation needs in Hong Kong^[19].

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Group Dynamics in Exercise Therapy - NGO Perspective

LEE Shuk Ming

Physiotherapist I, Heung Hoi Ching Kok Lin Association,
Buddhist Li Ka Shing Care and Attention Home for the Elderly

Exercise classes/groups are a staple of physiotherapy treatments in a NGO setting in conjunction with individual and bedside physiotherapy.

Clients that are not performing well in a one-on-one setting often do very well in group or exercise class. Below are some observations during physiotherapy exercise groups at the Buddhist Li Ka Shing Care and Attention Home for the Elderly. Treatment sessions usually last for an hour and consist of sensorimotor or cognitive activities and more often, involving both of them.

- 1) **Cooperation** among group members. To accomplish a task or achieve a goal, e.g. passing a ball (sandbag or dumbbell) from one to another until the last person who gets the object places on a table or inside a box.
- 2) **Problem solving**. "Two brains are better than one". More people in a group can create more ideas through brainstorming activities and problems-solving; and this is an important component in group activities.
- 3) **Interaction** between group members. Exercises can be repetitive and boring if performed alone. In a group setting, exercises can be fun and interactive. Time passes quickly and all clients have to participate and finish the group works together. Clients also show increase in verbal and social skills over time.
- 4) **Competitiveness** among group members. There is nothing like a little "healthy competition" to motivate a group of clients. Clients participate more and try their best in order to edge out others, e.g. many types of ball games or sports can be modified to suit the elderly clients. Elderly Olympics, wheelchair basketball, soccer, volleyball and hockey games are fun and easy to set up for the elderly.
- 5) **Leadership skills**. Clients who are good at certain areas can develop leadership skills in a group setting. This in turn increases self-esteem and the client feels a sense of achievement.
- 6) **Peer pressure**. Clients who lack motivation are pushed (in a positive way) to perform or at least try to perform due to peer pressure.
- 7) Exercise groups are **cost effective** and time saving. 10 to 12 clients or more may attend an exercise group so more clients can benefit at the same time and it is an efficient use of limited therapists' time.
- 8) Clients with homogeneous disease in an exercise group can serve as **mutual support** so that experiences can be shared and learned from each other, e.g. clients in fall prevention groups can discuss the possible reasons of Fall; whereas postural and gait training groups can critique each other's postural and gait. They enjoy the process and most of them are able to improve and empower themselves through positive feedbacks and self-learning skills.



Unapproved Titles or Descriptions

Bronco BUT

Honorary Legal Advisor of HKPA

Assumed Scenario

Anna was a Part 1a registered physiotherapist and member of Hong Kong Physiotherapy Association. She had practised physiotherapy in a public hospital for many years. Recently, she resigned and partnered with Louisa, her physiotherapy classmate to set up a private physiotherapy clinic which was owned by Anna and Louisa.

After graduation from Hong Kong Polytechnic University, Anna had undergone various trainings including but not limited to acupuncture. She asked Louisa to arrange the printing of her professional cards. Since she was busily engaged in treating patients, she was not bothered to check the contents of her professional cards, showing amongst others, titles and descriptions of 普拉提(墊上)運動教練, 關節炎太極導師, 香港痛症學院針灸學文憑, TRX團體訓練證書, 產前產後體適能運動課程證書.

One day, she received a Notice of Inquiry from Physiotherapists Board saying that:

"Anna, being a Part 1a physiotherapist, sanctioned, acquiesced in or failed to take adequate steps to prevent the use of the following unapproved titles and descriptions in her professional cards, namely 普拉提(墊上)運動教練, 關節炎太極導師, 香港痛症學院針灸學文憑, TRX團體訓練證書, 產前產後體適能運動課程證書 and that in relation to the facts alleged, she has been guilty of unprofessional conduct.

Code of Practice

The Physiotherapists Board has promulgated the Code of Practice for physiotherapists to observe and follow. The purpose of the Code is to provide guidance for conduct and relationships in carrying out the professional responsibilities consistent with the professional obligations of the profession.

A registered physiotherapist should observe the basic ethical principles outlined in Part I of the Code; understand the meaning of "unprofessional conduct" explained in Part II; and be aware of the conviction and forms of professional misconduct detailed in Part III which may lead to disciplinary proceedings.

A person who contravenes any part of the Code of Practice may be subject to inquiries held by the Board but the fact that any matter not mentioned in the Code,

shall not preclude the Board from judging a person to have acted in an unprofessional or improper manner by reference to those matters.

Section 9 of Part III of the Code of Practice

By Section 9 in Part II, the Board has warned physiotherapists specifically against reference to positions held, employment, honorary appointment, or experience and qualifications which are unregistrable or not acceptable to the Board, on signboards, stationery, visiting cards, letter heads, envelopes, prescription ships, notices, etc. A list of qualifications acceptable to the Board in the approved Chinese and English abbreviated forms is issued to all registered physiotherapists. Copies may be obtained from the Secretary, Physiotherapists Board of Hong Kong. Any registered physiotherapist who uses any title or description which may reasonably suggest that he possesses any professional status or qualifications, other than those which he in fact does possess, will in the opinion of the Board, be guilty of unprofessional conduct. In general, the Board considers that any act or omission by a registered physiotherapist in connection with his practice which may mislead the public may be held to constitute unprofessional conduct.

Discussions

Anna did in fact possess the relevant qualifications and there is no evidence to suggest that she used these unapproved titles or qualifications with intent to mislead the public.

According to the List of Quotable Qualifications issued by the Board on 23 July 2013, the titles or descriptions used by Anna in her professional card, namely 普拉提(墊上)運動教練, 關節炎太極導師, 香港痛症學院針灸學文憑, TRX團體訓練證書 and 產前產後體適能運動課程證書 have not been approved by the Board as quotable qualifications.

In view of the aforesaid, it is likely that the Board would rule that Anna had been in breach of Section 9 and was guilty of unprofessional conduct.

Physiotherapists should make sure that they are fully conversant with the Code of Practice and double check the Code of Practice so as not to put themselves at risk of contravening the Code of Practice. No matter how busy they are, they should double check their professional cards before printing.

Occupational Safety, Health and Rehabilitation Specialty Group (OSHRSG)

Role of Physiotherapist in Workplace Assessment and Work Rehabilitation: the Australian Experience

Date : 13 September 2017

Venue : Hong Kong Physiotherapy Association Premises

Speaker : Dr. Jenny LEGGE

Dr. Legge is a business owner and Founder of the JobFit System; a vocational matching software that provides employers with workplace injury prevention and management decisions. Dr. Legge shared her experience of work rehabilitation and pre-employment screening in Australia from various perspectives of legislation, insurance companies, employers and case managers. Her sharing was very practical and useful for the application in Hong Kong. More than 20 colleagues participated in this interactive sharing and had a fruitful discussion with Dr. Legge.



Happy Happenings

Congratulations to Prof. Marco PANG

Prof. Pang represents the Asia Western Pacific Region to assume his new post as Executive Board Member of the World Confederation for Physical Therapy (WCPT) on 1 September 2017.



Emma Stokes (President of WCPT) and Prof. Marco Pang
at the WCPT World Congress held in Cape Town, South Africa in July 2017

Congratulations to Dr. Margaret MAK

Dr. Mak is appointed as "Shun Hing Education and Charity Fund Endowed Fellowship in Rehabilitation Sciences" for her renowned research excellence. She is the first academics granted with this award in the Hong Kong Polytechnic University. We sincerely wish her every success on her ongoing researches in Parkinsonism Rehabilitation with the support of the fellowship.



(from left to right) Mr. TC Chan JP, PolyU Council Chairman, Mr. T Chan, Dr. Margaret Mak, Representative from the Donor, and Prof. T Tong, President of PolyU.



Colleagues of Department of RS, PolyU shared the happiness with Dr. Mak.

Letter to Physiotherapists Board Hong Kong

Physiotherapists Board Hong Kong
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21 Aug 2017

Dear secretariat of the Physiotherapists Board Hong Kong,

Notification on the Result of Public Survey on Referral to Physiotherapy

Related to the issue on open access for physiotherapy services in Hong Kong, the Hong Kong Physiotherapy Association (HKPA) conducted a survey to find out the opinions of general public of Hong Kong regarding their right to choose "doctor's referral or self-referral" to physiotherapy. The executive summary is listed as below:

"Patients can self-refer to physiotherapy in most developed countries while a doctor referral is required for patients in Hong Kong. With the increasing pressure facing by the primary health care system and increasing capacity of patients in Hong Kong, an option between doctor's referral and self-referral to physiotherapy is revisited. The main purpose of this survey was to find out the opinions of general public of Hong Kong regarding their right to choose "doctor's referral or self-referral" to physiotherapy. This report contains the results of the physiotherapy referral survey undertaken between December 2016 and March 2017. A total of 1,004 questionnaires with a wide coverage of different districts of Hong Kong were collected by face-to-face interview with the public. Results from the survey showed that there is a high demand for physiotherapy service in Hong Kong and majority of the respondents (88.9%) agree that citizens of Hong Kong deserve the right to choose "doctor's referral" or "self-referral" to access physiotherapy service."

The full report of the "Public Survey on Referral to Physiotherapy" is also appended for your reference & record keeping.

We welcome for further discussion by making contact with the undersigned if required.

Yours sincerely,



Ms. Priscilla POON

Apply for Fellowship in HONG KONG COLLEGE OF PHYSIOTHERAPY

The Fellow (Cardiopulmonary) and
Fellow (Musculoskeletal) of HKCOP are
Quotable Qualifications Approved by
the Physiotherapists Board.

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