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-DECONDIZIONAMENTO E RIADATTAMENTO ALLO SFORZO

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-ASPETTI POSITIVI DEL FUNZIONAMENTO IN OTTICA ICF
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-CRITERI DI EVOLUTIVITÀ DELLE SCOLIOSI IDIOPATICHE
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COPPIA N.32
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-IL RAZIONALE DEL TRATTAMENTO POST CHIRURGICO DELLA PROTESI DI TOTALE DEL GINOCCHIO NEL PAZIENTE ANZIANO
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COPPIA N.34
-IL RAZIONALE DEL TRATTAMENTO **POST CHIRURGICO** DELLA LESIONE DEL LEGAMENTO CROCIATO ANTERIORE NEL PAZIENTE GIOVANE
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-IL CONTROLLO POSTURALE NELLA POSIZIONE SEDUTA NEL PAZIENTE EMIPLEGICO: IL RAZIONALE DEL TRATTAMENTO
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COPPIA N.38
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-SECONDO I PRINCIPI ERGONOMICI, QUALI SONO I CORRETTI PASSAGGI POSTURALI ASSISTITI DALLA POSIZIONE SUPINA A QUELLA SEDUTA IN CARROZZINA DI UN PAZIENTE ANZIANO IPOCINETICO **COLLABORANTE**

COPPIA N.39
-QUALI AUSILI E FACILITAZIONI SI POSSONO ADOTTARE PER IL TRASFERIMENTO CARROZZINA LETTO IN UN PAZIENTE ANZIANO IPOCINETICO **NON COLLABORANTE** SEGUENDO I PRINCIPI ERGONOMICI
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-SINTOMI POSITIVI NELLA SINDROME DEL PRIMO MOTONEURONE
-RIEDUCAZIONE POSTURALE NEL PAZIENTE AFFETTO DA ARTRITE REUMATOIDE

COPPIA N.45
-IPERCIFOSI: VALUTAZIONE E TRATTAMENTO
-SINDROME COMPRESSIVA DEL NERVO RADIALE: PROPOSTE DI TRATTAMENTO **CONSERVATIVO**

COPPIA N.46
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-DEFINIZIONE DEL CONCETTO BOBATH ED ESEMPIO DI APPLICAZIONE

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-PRINCIPI ED APPLICAZIONE DEL METODO RPG (SOUCHARD)
-INSTABILITA' ANTERIORE DELLA SPALLA NEL PAZIENTE GIOVANE: TRATTAMENTO CONSERVATIVO

COPPIA N.49
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-QUALI MOVIMENTI SONO SCONSIGLIATI AL PZ OPERATO DI PROTESI D'ANCA CON ACCESSO POSTERO LATERALE

COPPIA N.50
-SEGNI E SINTOMI NELLA DISFUNZIONE TEMPOROMANDIBOLARE
-DEFINZIONE DI SINDROME DI GUILLANE-BARRE': PROPOSTE DI TRATTAMENTO

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-DEFINIZIONE DEL CORE COMPETENCE DEL FISIOTERAPISTA.
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-NELLA PRATICA RIABILITATIVA COSA SI INTENDE PER "COMPENSO"
-ESERCIZI DI STABILIZZAZIONE DELLA COLONNA LOMBARE

COPPIA N.53
-STENOSI DEL CANALE SPINALE, DEFINIZIONE, VALUTAZIONE , TRATTAMENTO
-OBIETTIVI PRIORITARI E LE STRATEGIE OPERATIVE PREVISTE PER LA GESTIONE A LUNGO TERMINE DELLE ADL NEL PAZIENTE AFFETTO DA ARTRITE REUMATOIDE

COPPIA N.54
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-PROPOSTE DI TRATTAMENTO CONSERVATIVO NELLA SPONDILOLISTESI
-DISTURBI NON MOTORI PIU' FREQUENTI CONSEGUENTI A LESIONE EMISFERICA DESTRA

COPPIA N.56
-DEFINIZIONE DI ANOSOGNOSIA
-IL TRATTAMENTO RIABILITATIVO NELLE FRATTURE DI COLLES

COPPIA N.57
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-TRATTAMENTO POSTCHIRURGICO NELLA SINDROME DEL TUNNEL CARPALE
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-ORTESI PER L'ARTO SUPERIORE NEL PAZIENTE EMIPARETICO
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COPPIA N.60
-ORTESI PER L'ARTO INFERIORE NEL PAZIENTE EMIPARETICO
-PROPOSTE DI TRATTAMENTO CONSERVATIVO NEL DOLORE FEMORO ROTULEO

COPPIA N.61
-L'ESERCIZIO TERAPEUTICO DEL PAZIENTE CON SCOLIOSI IDIOPATICA
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COPPIA N.62
-QUADRI CLINICI DELLA SPASTICITÀ POST-ICTALE DELL'ARTO INFERIORE
-CARATTERISTICHE DELLA LOMBALGIA MECCANICA

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-SCALE DI MISURA DEL DOLORE
-LUSSAZIONI DI SPALLA RECIDIVANTI: PROPOSTE DI TRATTAMENTO

COPPIA N.64
-APPROCCIO RIABILITATIVO NEL PAZIENTE GERIATRICO OSPEDALIZZATO: RUOLO DEL FISIOTERAPISTA
-DEFINIZIONE DI NEGLIGENZA SPAZIALE (NEGLECT)

COPPIA N.65
-IL RICONDIZIONAMENTO MOTORIO DEL PAZIENTE GERIATRICO IN ASSISTENZA DOMICILIARE INTEGRATA :RUOLO DEL FISIOTERAPISTA
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-SEGNI E SINTOMI DELLA DISFUNZIONE TEMPOROMANDIBOLARE

COPPIA N.67
-L'UTILIZZO DEGLI AUSILII NELLA MOVIMENTAZIONE MANUALE DEL PAZIENTE
-COMPLICANZE DOPO INTERVENTO DI ARTROPROTESI DI ANCA

COPPIA N.68
-FATTORI DI RISCHIO PER LA CRONICIZZAZIONE DELLA LOMBALGIA MECCANICA
-APPROCCIO RIABILITATIVO INTEGRATO NEL TRATTAMENTO DEL LINFEDEMA DELL'ARTO SUPERIORE POST MASTECTOMIA

COPPIA N.69
-ESERCIZI ECCENTRCI VS ESERCIZI CONCENTRICI
-SINDROME DELLA SPALLA DOLOROSA NEL PAZIENTE EMIPLEGICO: PREVENZIONE E TRATTAMENTO

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-ESERCIZI PROPRIOCETTIVI NELLA RIABILITAZIONE DELLA DISTORSIONE DI CAVIGLIA
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COPPIA N.71
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-LOMBALGIA DA DISFUNZIONE POSTURALE: OSSERVAZIONE , VALUTAZIONE E PROGRAMMA FISIOTERAPICO

COPPIA N.72
-SINDROME DOLOROSA DELL'ANCA
-VALUTAZIONE NEL PAZIENTE CON M.DI PARKINSON

COPPIA N.73
-SCLEROSI MULTIPLA: DEFINIZIONE ED APPROCCIO TERAPEUTICO
-VALUTAZIONE RISCHIO DI CADUTE NEL PAZIENTE ISTITUZIONALIZZATO

COPPIA N. 74
-DECOMPRESSIONE SUBACROMIALE : IL RAZIONALE DEL TRATTAMENTO POSTOPERATORIO
-DESCRIVERE GLI ASPETTI DA CONSIDERARE PER LE TECNICHE DI ESECUZIONE DEL SOLLEVAMENTO DI PESI IN SICUREZZA

COPPIA N.75
-L'APPROCCIO TERAPEUTICO AL PAZIENTE CON BPCO
-CONCETTO DI FACILITAZIONE MOTORIA ED ESEMPIO DI APPLICAZIONE AL TRATTAMENTO DEL PAZIENTE EMIPLEGICO

COPPIA N. 76
-SINDROME DOLOROSA DELLA SPALLA DA CONFLITTO: TRATTAMENTO CONSERVATIVO
-SINTOMI POSITIVI NELLA SINDROME DEL I° MOTONEURONE

COPPIA N°77
-SINERGIE PATOLOGICHE DOMINANTI NELL'ARTO SUPERIORE PLEGICO
-DISFUNZIONI MUSCOLOSCHELETRICHE NEL PAZIENTE CON BPCO

1. **L'acronimo RAM sta per?**

2. **A cosa servono le unità disco?**

3. **Dove si trova la scheda madre ?**

4. **Che estensione hanno i file di word?**

5. **Per spegnere il computer (con sistema operativo Windows XP), quale successione di comandi devo usare?**

6 **Per ingrandire una finestra a tutto schermo clicco sul comando rappresentato da ?**

7 **Genericamente, una cartella è rappresentata da quale icona ?**

8 **Come si crea una cartella ?**

9 Come si cambia il nome di un File ?

10 Come si fa per visualizzare il contenuto di una cartella ?

11 Come si elimina un file ?

12 I file che si trovano nel cestino come possono essere recuperati ?

13 Che tipo di computer è il notebook?

14 A cosa serve Outlook Express?

15 Per memorizzare un documento che stiamo scrivendo per la prima volta, al comando *Salva con Nome* cosa occorre indicare?

16 Quali sono i tipi di allineamento dei paragrafi consentiti ?

17 Cosa si visualizza Nella coda di stampa ?

18 Che cos'è il desktop?

19 Che estensione hanno i file di Power Point?

20 Che estensione hanno i file di immagini?

21. Cosa significa WWW?

22. Che cos'è una homepage?

23. A cosa serve il backup?

24. Che cos'è un pdf?

25. Che cos'è un gigabyte?

26. GIF è un formato utilizzato per quale tipo di file?

27. A cosa serve il mouse?

28. A cosa serve la combinazione Ctrl+ Alt+Canc?

29. Cosa si intende per e-learning?

30. Quale operazione è utile a riorganizzare lo spazio su disco fisso?

31. Quale applicativo di Microsoft Office crea fogli di calcolo elettronici?

32. Quale periferica del computer bisogna utilizzare per memorizzare in formato digitale una pagina di un quotidiano?

33. Su una tastiera estesa per PC il tasto "Bloc Num" che funzione ha?

34. Che cos'è un browser?

35.Qual è il termine che identifica una sequenza di diapositive?

36. In Windows, l'estensione ".txt" che segue il nome del file, designa..?

37. Per correggere un testo dagli errori di battitura, quale operazione è necessario eseguire?

38. Quale sequenza di operazioni, su un elaboratore testi (ad esempio Word), sposta un testo in un'altra posizione?

39. Quali sono i programmi che compongono il pacchetto Offfice?

40. Quale programma di Office viene usato con funzione di database?

41. Per inserire una tabella in Word quale sequenza di comandi si deve eseguire?

42. Nel programma Word, qual è l'opzione da scegliere per vedere come apparirà un documento stampato?

43. In Windows, l'estensione ".doc" che segue il nome del file, significa che il file deve essere aperto con quale programma?

44. in Windows, l'estensione ".xls" che segue il nome del file, significa che il file deve essere aperto con il programma?

45.Quale tasto permette di cancellare il testo posto a destra del cursore?

46. Quale tasto si deve premere per interrompere l'esecuzione di una presentazione?

47. La funzione Cronologia cosa permette di visualizzare?

48. Una formula di Excel deve iniziare sempre con quale simbolo?

49. Da cosa è individuata una riga in un foglio di lavoro Excel?

50. Un paragrafo quando si dice giustificato?

51. Cosa indica l'estensione di un file?

52. In Word il pulsante con un pennello a cosa serve?

53. A cosa serve il programma Excel?

54. Qual è la memoria centrale di un computer?

55. Indicare una tipologia di memoria di massa

56. Che cos'è Windows Media Player?

57.Quale programma apre un file pdf?

58. Cosa identifica la risoluzione di un monitor?

59. Cosa sono i touch screen?

60. Cos'è la posta elettronica certificata?

61.Il termine ROM è l'acronimo di?

62. Il disco fisso come può essere anche chiamato?

63. La tastiera è una periferica di inputo o output?

64. . edu in dominio sta per?

65. Qual è il sistema di trasmissione dati senza fili via onde radio?

66. Quale operazione consente di scaricare un file da internet sul pc?

67. Quale tasto serve ad andare a capo in un programma di scrittura?

68. quale combinazione di tasti permette di tagliare una porzione di testo in un file word?

69. Quale combinazione di tasti permette di incollare una porzione di testo precedentemente tagliata?

70. Che cos'è Power Point?

71. Che cos'è Access?

72. Che cos'è un e-mail?

73. A cosa serve la barra degli indirizzi di una finestra windows?

74.Lla linea rossa ondulata sotto una parola in un documento di Word cosa indica?

75. Per modificare lo spazio tra un paragrafo e l'altro in un documento significa modificare?

1

Presurgery exercise-based conditioning interventions (prehabilitation) in adults undergoing lower limb surgery for peripheral arterial disease (Cochrane review) [with consumer summary]

Palmer J, Pymer S, Smith GE, Harwood AE, Ingle L, Huang C, Chetter IC

Cochrane Database of Systematic Reviews 2020;Issue 9

systematic review

BACKGROUND: Lower limb peripheral arterial disease (PAD) is a type of cardiovascular disease where the blood vessels that carry the blood to the legs are hardened and narrowed. The most severe manifestation of PAD is critical limb ischaemia (CLI). This condition results in symptoms of intractable rest pain, non-healing wounds and ulceration, gangrene or both. PAD affects more than 200 million people worldwide and approximately 3% to 5% of people aged over 40 have PAD, rising to 18% in people over 70 years of age.

2

Treatment options include angioplasty, bypass or amputation of the limb, when life or limb is threatened. People with CLI have a high risk of mortality and morbidity. The mortality rates during a surgical admission are approximately 5%. Within one year of surgery, the mortality rate rises to 22%. Postoperative complications are as high as 30% and readmission rates vary between 7% to 18% in people with CLI. Despite recent advances in surgical technology, anaesthesia and perioperative care, a proportion of surgical patients have a suboptimal recovery.

3

The use of prehabilitation is gaining momentum, particularly in elderly patients undergoing surgery and patients undergoing colorectal cancer surgery, as a means of optimising fitness to improve the prognosis for people undergoing the physiological stress of surgery. People with PAD are characterised by poor mobility and physical function and have a lower level of fitness as a result of disease progression. Therefore, prehabilitation may be an opportunity to improve their recovery following surgery.

4

This review aimed to compare prehabilitation with usual care (defined as a preoperative assessment, including blood and urine tests). The key outcomes were postoperative complications, mortality and readmissions within 30 days of the surgical procedure, and one-year survival rates. OBJECTIVES: To assess the effectiveness of prehabilitation (preoperative exercise, either alone or in combination with nutritional or psychological interventions, or both) on postoperative outcomes in adults with PAD undergoing open lower limb surgery.

5 Two review authors independently reviewed all records identified by the searches conducted by the Cochrane Vascular Information Specialist. We planned to undertake data collection and analysis in accordance with recommendations described in the Cochrane Handbook for Systematic Reviews of Interventions. MAIN RESULTS: We found no RCTs that met the inclusion criteria for this review. AUTHORS' CONCLUSIONS: We found no RCTs conducted to determine the effects of prehabilitation on mortality or other postoperative outcomes when compared to usual care for patients with PAD.

6 **The effectiveness and cost-effectiveness of hospital-based specialist palliative care for adults with advanced illness and their caregivers (Cochrane review) [with consumer summary]**

Bajwah S, Oluyase AO, Yi D, Gao W, Evans CJ, Grande G, Todd C, Costantini M, Murtagh FE, Higginson IJ

Cochrane Database of Systematic Reviews 2020;Issue 9

systematic review

BACKGROUND: Serious illness is often characterised by physical/psychological problems, family support needs, and high healthcare resource use. Hospital-based specialist palliative care (HSPC) has developed to assist in better meeting the needs of patients and their families and potentially reducing hospital care expenditure. There is a need for clarity on the effectiveness and optimal models of HSPC, given that most people still die in hospital and also to allocate scarce resources judiciously.

7 We used standard methodological procedures expected by Cochrane. We assessed risk of bias and extracted data. To account for use of different scales across studies, we calculated standardised mean differences (SMDs) with 95% confidence intervals (CIs) for continuous data. We used an inverse variance random-effects model. For binary data, we calculated odds ratio (ORs) with 95% CIs. We assessed the evidence using GRADE and created a 'Summary of findings' table. Our primary outcomes were patient health-related quality of life (HRQoL) and symptom burden (a collection of two or more symptoms).

8 We identified 42 RCTs involving 7,779 participants (6,678 patients and 1,101 caregivers/family members). Twenty-one studies were with cancer populations, 14 were with non-cancer populations (of which six were with heart failure patients), and seven with mixed cancer and non-cancer populations (mixed diagnoses). HSPC was offered in different ways and included the following models: ward-based, inpatient consult, outpatient, hospital-at-home or hospital outreach, and service provision across multiple settings which included hospital. For our main analyses, we pooled data from studies reporting adjusted endpoint values.

9 HSPC also improved other person-centred outcomes. It reduced patient symptom burden with a small effect size of -0.26 SMD over usual care (95% CI -0.41 to -0.12; I2 = 0%, 6 studies, 761 participants, very low-quality evidence, lower scores indicate lower symptom burden). HSPC improved patient satisfaction with care with a small effect size of 0.36 SMD over usual care (95% CI 0.41 to 0.57; I2 = 0%, 2 studies, 337 participants, low-quality evidence, higher scores indicate better patient satisfaction with care)

10 wo studies (170 participants) presented data on caregiver burden and both found no evidence of effect of HSPC (very low-quality evidence). We included 13 economic studies (2,103 participants). Overall, the evidence on cost-effectiveness of HSPC compared to usual care was inconsistent among the four full economic studies. Other studies that used only partial economic analysis and those that presented more limited resource use and cost information also had inconsistent results (very low-quality evidence)

11 Quality of the evidence The quality of the evidence assessed using GRADE was very low to low, downgraded due to a high risk of bias, inconsistency and imprecision. AUTHORS' CONCLUSIONS: Very low- to low-quality evidence suggests that when compared to usual care, HSPC may offer small benefits for several person-centred outcomes including patient HRQoL, symptom burden and patient satisfaction with care, while also increasing the chances of patients dying in their preferred place (measured by home death).

12 While we found no evidence that HSPC causes serious harms, the evidence was insufficient to draw strong conclusions. Although these are only small effect sizes, they may be clinically relevant at an advanced stage of disease with limited prognosis, and are person-centred outcomes important to many patients and families. More well conducted studies are needed to study populations with non-malignant diseases and mixed diagnoses, ward-based models of HSPC, 24 hours access (out-of-hours care) as part of HSPC, pain, achieving patient preferred place of care, patient satisfaction with care, caregiver outcomes (satisfaction with care, burden, depression, anxiety, grief, quality of life)

13

Efficacy and safety of exercise rehabilitation for heart failure patients with cardiac resynchronization therapy: a systematic review and meta-analysis

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systematic review

BACKGROUND: Many heart failure (HF) patients admitted to cardiac rehabilitation (CR) centers have a cardiac resynchronization therapy (CRT) device. However, information about the efficacy and safety of exercise rehabilitation in HF patients with a CRT device is scant. We assessed the effects of exercise rehabilitation in HF patients with a CRT device.

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China Biology Medicine, Wanfang, and China National Knowledge Infrastructure databases were searched comprehensively to identify randomized controlled trials (RCTs) published between January 1, 1990 and July 1, 2019 on exercise rehabilitation in HF patients with CRT devices. We identified seven studies published from 2006 to 2019, including 661 patients with an intervention duration of 8 to 24 weeks. Three studies reported all-cause mortality and serious adverse events, and no significant difference was found between exercise rehabilitation patients and controls

15

Due to differences in health-related quality of life (HRQOL) assessment methods, we only pooled data that reported Minnesota Living with Heart Failure Questionnaire scores. Exercise rehabilitation patients exhibited a better HRQOL than controls (fixed-effect WMD -5.34, 95% CI -10.12 to -0.56; p = 0.028; I2 = 0%). CONCLUSION(S): Exercise rehabilitation may restore exercise capacity and cardiac function in HF patients with a CRT device. Furthermore, exercise training was associated with better HRQOL on follow-up.

16

Background: Many heart failure (HF) patients admitted to cardiac rehabilitation (CR) centers have a cardiac resynchronization therapy (CRT) device. However, information about the efficacy and safety of exercise rehabilitation in HF patients with a CRT device is scant. We assessed the effects of exercise rehabilitation in HF patients with a CRT device.Infrastructure databases were searched comprehensively to identify randomized controlled trials (RCTs) published between January 1, 1990 and July 1, 2019 on exercise rehabilitation in HF patients with CRT devices. We identified seven studies published from 2006 to 2019,

17

Cardiac rehabilitation (CR) is a widely accepted treatment strategy for chronic HF patients and has been proven to reduce mortality and improve exercise capacity, heart function, HRQOL, and prognosis (Piepoli et al., 2004; van Tol et al., 2006). However, most published studies focus on the effect of exercise rehabilitation on New York Heart Association (NYHA) I-II patients with HF, with little research paying attention to NYHA II-IV HF patients. HF patients with indications of CRT implantation tend to have a higher level of NYHA functional class (Yancy et al., 2013).

18 Cardiac resynchronization therapy (CRT) is currently a well-established treatment for HF patients with severe left ventricular systolic dysfunction and ventricular systolic dyssynchrony (Bristow et al., 2004; Cleland et al., 2005). A number of clinical randomized controlled trials (RCTs) have shown that a CRT device can improve heart function and structure, health-related quality of life (HRQOL), and exercise capacity and reduce hospitalization and mortality in progressive HF patients (Duncan et al., 2003; Cleland et al., 2006; Tang et al., 2010). However, approximately 20–30% of patients show little or no response (Abraham et al., 2002).

19 Cardiac rehabilitation (CR) is a widely accepted treatment strategy for chronic HF patients and has been proven to reduce mortality and improve exercise capacity, heart function, HRQOL, and prognosis (Piepoli et al., 2004; van Tol et al., 2006). However, most published studies focus on the effect of exercise rehabilitation on New York Heart Association (NYHA) I-II patients with HF, with little research paying attention to NYHA II-IV HF patients. HF patients with indications of CRT implantation tend to have a higher level of NYHA functional class (Yancy et al., 2013).

20 Two authors (SW and LY) independently extracted the relevant data from eligible articles using a predesigned data extraction form. The article titles and abstracts were first screened to identify potentially eligible studies and then the full paper was reviewed. Any disagreements were resolved through discussion. The extracted information included the first author, publication year, sample size, exercise training duration, follow-up time, echocardiographic measures (LVEF, LVEDD), exercise capacity (peak VO_2, exercise duration), HRQOL, adverse events (all-cause mortality, serious adverse events), and exercise rehabilitation protocol.

21 A preliminary search of the literature yielded 1,203 articles. One hundred and forty-six papers were duplicates, 157 papers were reviews, and 881 papers were excluded based on titles and abstracts. The full text of the remaining articles was retrieved and evaluated according to the inclusion criteria. The reasons for the exclusion of 12 articles were as follows: five articles provided incomplete data, five articles were designed as non-RCTs, and two articles reported the same cohort. In the end, seven studies (Belardinelli et al., 2006; Conraads et al., 2007; Patwala et al., 2009; Smolis-Bak et al., 2015; Zeitler et al., 2015; Nobre et al., 2016; Santa-Clara et al., 2019) were identified for analysis. The PRISMA flow chart for this meta-analysis is presented in Figure 1. The characteristics of the studies and participants are shown in Tables 1, ,22.

Exercise Capacity

22 Seven trials with a total of 560 participants reported results on peak VO_2. Compared to controls, pooled peak VO_2 was higher with exercise rehabilitation (random-effect WMD = 2.02 ml/kg/min, 95% CI 0.62 to 3.41; $P = 0.005$; $I^2 = 67.4\%$, Figure 3A). The sources of heterogeneity were determined by the Galbraith plot, and there was significant heterogeneity in two of the studies (Supplementary Image 1). The heterogeneity was remarkably decreased after excluding these two studies, and the differences remained significant (random-effect WMD = 1.88 ml/kg/min, 95% CI 0.88 to 2.89; $P < 0.001$; $I^2 = 34.2\%$). There was no significant change in the pooled effect by sensitivity analysis.

Health-Related Quality of Life

23 Six trials used a variety of assessment scales to assess HRQOL. Considering the heterogeneity of different assessment scales, we did not conduct a meta-analysis across the various HRQOL measures. However, in the subgroup of three comparisons reporting the total score on the Minnesota Living with Heart Failure Questionnaire, the results showed that the exercise rehabilitation

24 We assessed the evidence for all outcomes as low to moderate quality. The exercise rehabilitation programs consisted of all seven trials of both aerobic exercise and resistance training or stretching. The dose of exercise training ranged widely across the trials from two to five sessions per week and a duration of 15 to 60 min per session for a period of 8 to 24 weeks. The intensity of exercise in most studies was moderate, while the highest intensity was 95% of the peak heart rate. The trials had different approaches to their control group.

25 The meta-analysis showed that there was no evidence of a difference in all-cause mortality or serious adverse events in patients who received exercise rehabilitation and controls at the longest available follow-up. The results illustrated that exercise rehabilitation seems to be safe. However, these results must be interpreted cautiously because of the small sample sizes and short follow-up periods. Meanwhile, exercise rehabilitation had failed to decrease cardiovascular mortality and serious adverse events. Similarly, due to the risk of type II error, we take a conservative approach to the conclusions.

26 Previous studies have shown that the clinical benefits of CRT are reduced in patients with a history of atrial fibrillation (Wilton et al., 2011; Healey et al., 2012). AF hinders atrioventricular optimization of CRT and may reduce cardiac output (Gasparini et al., 2013). Most of the included studies included different proportions of people with atrial fibrillation. However, this meta-analysis failed to further analyze the effect of heart rhythm on the synergistic effect of CRT and exercise rehabilitation. Xavier et al. reported patients in AF or sinus rhythm (SR)with a CRT device shown distinct benefits from CRT implantation and from exercise rehabilitation

27 HF is a systemic syndrome that includes central hemodynamic changes and peripheral abnormalities. The "muscle hypothesis of cardiac failure" has been proposed to explain the peripheral abnormalities. This hypothesis proposes that inadequate skeletal muscle perfusion activates muscle ergoreceptors, leading to neurohormone activation and peripheral vasoconstriction, which stimulates the progression of the disease (Clark et al., 1996). A CRT device improves the central cardiac function, but has no significant effects on the peripheral skeletal muscle, except for muscle sympathetic nerve activity (Kuniyoshi et al., 2014).

28 Our study was not without limitations. First, since there are relatively few studies on this issue, we only included seven studies in this meta-analysis. Most trials were relatively small and reported few clinical events. Second, the possibility of selection bias cannot be ruled out as only published trials were included in the meta-analysis. Third, a longer intervention period might affect outcomes, as the follow-up duration and exercise program duration might be too short for clinical outcomes.

29 Fourth, although the trials had different approaches to the control groups, we grouped the control groups into a single control group which may have been too much of a simplification. Fifth, the intensity and duration of the exercise training in the included studies varied, and we grouped all interventions into a single intervention group, which may have also been too much of a simplification.

30 Our study findings suggest that exercise rehabilitation could significantly improve exercise capacity and heart function in HF patients with a CRT device. Furthermore, exercise rehabilitation was associated with a higher HRQOL on follow-up. These findings support a broader application of exercise rehabilitation among HF patients with a CRT device. Future studies are needed to assess the effects of exercise training on long-term clinical outcomes among HF patients with a CRT device.

31 The benefits of inspiratory muscle training (IMT) have already been demonstrated in patients with heart failure (HF), but the best mode of training and which patients benefit from this intervention are not clear. The purpose of this study was to review the effects of IMT on respiratory muscle strength, functional capacity, pulmonary function, quality of life, and dyspnea in patients with HF; IMT isolated or combined with another intervention (combined IMT), the presence of inspiratory muscle weakness, training load, and intervention time were considered.

32 The search included the databases MEDLINE, EMBASE, Cochrane Central Register of Controlled Trials, Physiotherapy Evidence Database, and LILACS database through September 2019. The review included randomized studies that assessed IMT in isolation or combined with another intervention—in comparison with a control group, a placebo, or another intervention—in patients with HF. Fourteen studies were included, 13 for meta-analysis (10 for isolated IMT and 3 for combined IMT).

33 Isolated IMT demonstrated an increase in maximal inspiratory pressure (MIP) (25.12 cm H_2O; 95% CI = 15.29 to 34.95), 6-minute walk test (81.18 m; 95% CI = 9.73 to 152.63), maximum oxygen consumption (12 weeks: 3.75 mL/kg/min; 95% CI = 2.98 to 4.51), and quality of life (−20.68; 95% CI = −29.03 to −12.32). The presence of inspiratory muscle weakness, higher loads, and longer intervention times resulted in greater increases in MIP. IMT combined with another intervention demonstrated an increase only in MIP.

34 Isolated IMT resulted in an increase in inspiratory muscle strength, functional capacity, and quality of life. IMT combined with another intervention resulted only in a small increase in inspiratory strength. Isolated IMT with higher loads can be considered an adjuvant intervention, especially for those who do not adhere to conventional rehabilitation and who have respiratory muscle weakness.

35 A systematic review was necessary to review the effects of IMT on respiratory muscle strength, lung function, functional capacity, quality of life, and dyspnea in patients with HF. Various clinical issues important for a better training prescription were considered; these included whether the performance of the training IMT as a form of isolated training benefits patients with HF, whether the combination of IMT with another intervention has additional effects, whether any patient with HF can benefit from IMT (alone or combined with another intervention), and whether only patients who already have respiratory muscle weakness benefit.

36 Subjects with severe and very severe chronic obstructive pulmonary disease (COPD) present thoracoabdominal asynchrony (TAA) that reduces ventilatory efficiency and exercise capacity. However, no therapeutic intervention has focused on reducing TAA. The purpose of this study was to evaluate the effects of elastic tape (ET) on thoracoabdominal mechanics, dyspnea symptoms, exercise capacity, and physical activity level in nonobese male subjects with severe-to-very severe COPD.

37 This crossover, randomized trial included nonobese males with severe to very severe COPD. ET was placed on the chest wall and abdomen to reduce TAA. Subjects were evaluated at three hospital visits, each 7 days apart. At *visit 1*, thoracoabdominal kinematic and pulmonary ventilation were evaluated by optoelectronic plethysmography and electrical impedance tomography, respectively, both at rest and during isoload exercise testing.

38 At *visit 2*, a cardiopulmonary exercise test (CPET; 10 W/min) was performed until exhaustion. Between the visits, subjects used a physical activity monitor (PAM) (at least 5 days of measurement; 10 h/day). At *visit 3*, all the tests were repeated in the opposite order of the previous randomization. During the isoload exercise, subjects with ET presented lower tidal and minute volumes ($P = 0.01$) and reduced TAA ($P = 0.02$) and dyspnea ($P = 0.04$). During the CPET, subjects with ET presented an increase in peak oxygen consumption ($\dot{V}o_{2peak}$; L/min and $mL \cdot kg^{-1} \cdot min^{-1}$; $P = 0.01$), test duration ($P = 0.009$), and maximal load ($P = 0.03$).

39 This paper provides an overview of a free resource that can be used by physiotherapists to assist their efforts to undertake evidence-based practice. The resource is the Physiotherapy Evidence Database (PEDro; www.pedro.org.au) – a searchable online database that in February 2019 indexes the details of over 42,000 pieces of published evidence about the effects of physiotherapy interventions. PEDro is searched millions of times each year by users worldwide.

40 The approach to the clinical care of patients known as "evidence-based practice" is becoming more widely accepted within the physiotherapy profession. The approach was defined by its developers as the "integration of the best research evidence with clinical expertise and patient values" [1]. Clinical physiotherapists who want their practice to be evidence-based must therefore identify the best evidence that is available to help inform their decisions about patient management.

41 It is difficult for physiotherapists to keep abreast of all the research that might be relevant to the types of patients they treat in clinical practice. One contributor to this difficulty is that, with ongoing publications, the number of trials of physiotherapy interventions is growing exponentially [2, 3]. If we consider physiotherapists who graduated in 2011, their university training could only have been based on about half of the evidence that currently exists about the efficacy of physiotherapy interventions.

42 Another issue is that it can be laborious to find the relevant evidence on databases. For example, if a physiotherapist wanted to find evidence about the effects of physiotherapy treatments for knee osteoarthritis, a search of 'knee osteoarthritis' on the PubMed database in February 2019 returned over 31,500 articles, many of which have nothing to do with physiotherapy interventions. Searching can be targeted towards more relevant articles but this requires a knowledge of sophisticated search strategies

43 This inefficiency is an important issue because most clinical physiotherapists have limited time to find and read evidence. It would be simpler and more efficient if physiotherapists seeking evidence to guide their clinical practice could use a database that indexed only research publications about the effects of physiotherapy interventions.

44 To address the situation described above, a group of physiotherapists established the Physiotherapy Evidence Database. More commonly referred to as 'PEDro', the database is freely available for anyone to use at www.pedro.org.au. This section of the paper will describe the content and features of PEDro, relating these to how they can assist physiotherapists who want to keep abreast of the growing body of evidence about physiotherapy interventions.

45 PEDro indexes the bibliographic details and abstracts of three types of documents. One type of document is *randomised clinical trials* of physiotherapy interventions (or interventions that could become part of physiotherapy care). Another type of document is *systematic reviews* that include at least one randomised trial of a physiotherapy intervention

46 The third type of document is *clinical practice guidelines* that are based on a systematic literature search and that contain at least one recommendation relevant to physiotherapy practice. Although there are other forms of evidence (for example, inception cohort studies provide evidence about prognosis), the most unbiased evidence about the effects of interventions comes from the forms of evidence indexed on PEDro: randomised trials, systematic reviews and clinical practice guidelines.

47 In February 2019, PEDro indexed over 33,000 trials, over 8000 systematic reviews, and over 650 clinical practice guidelines. The trials examine interventions from a wide range of subdisciplines, as shown in Fig. 1. This figure illustrates that the subdisciplines *musculoskeletal*, *cardiothoracics*, *neurology* and *gerontology* contribute the greatest share of records to PEDro, although even the subdisciplines with the fewest records have substantial evidence for interested users.

48 The sustained exponential growth in research into the effects of physiotherapy interventions generates a wonderful body of evidence for the profession to draw upon. However, it also portrays the growing difficulty that a physiotherapist, whether working clinically or in academia, would have in keeping abreast of the evidence relevant to their areas of interest.

49 As discussed at the beginning of this paper, searching a general database for high-quality evidence about physiotherapy interventions is inefficient. Even if the desired study design (eg, randomised trial, systematic review) is successfully incorporated into the search terms, it is still likely that many trials or reviews related to surgery, medication or other non-physiotherapy interventions will be retrieved.

In addition to targeting evidence about physiotherapy interventions, searches of PEDro are designed to be efficient in other ways. Searches can specify the type of therapy from a pull-down menu that includes 13 categories. These categories (in order of the amount of evidence available on PEDro) are: fitness training; strength training; education; stretching, mobilisation, manipulation or massage; skill training; behaviour modification; electrotherapy, heat or cold

In addition, searches can specify the problem experienced by the patient from a pull-down menu that includes 12 categories. These categories (in order of the amount of evidence available on PEDro) are: pain; reduced exercise tolerance; muscle weakness; motor incoordination; impaired ventilation; muscle shortening or reduced joint compliance; frailty; incontinence; oedema; reduced work tolerance; difficulty with sputum retention; and skin lesion, wound or burn.

If a particular known paper is required, then PEDro can also be searched by entering whichever of the following citation details are known: journal, year of publication, author, and words in the title. In fact, any combination of the search fields that have been mentioned so far can be used in a search.The study design of the desired evidence (randomised trial, systematic review or clinical practice guideline) is another field that can be specified from a pull-down menu.

The PEDro Scale includes items related to methodological quality and completeness of statistical reporting, resulting in a score out of 10 (with 0/10 being low and 10/10 being high quality) [7]. Several studies have reported acceptably high reliability for individual ratings and consensus ratings of both the English [7] and Portuguese [8] versions of the PEDro Scale.

The order in which search results are listed on the site is associated with how often the indexed research papers are accessed by users of PEDro. Specifically, synthesis research (ie, guidelines and reviews) are more commonly accessed than trials; Cochrane reviews are more commonly accessed than other reviews; and trials with higher PEDro Scale summary scores are more commonly accessed than lower quality trials [11].

When users of PEDro run a search, the results are initially presented as a list of titles. If a user sees a paper listed in the search results that might be of interest, clicking on it will reveal further details, such as the abstract (subject to copyright approval from the publisher), the full details of which PEDro Scale items were achieved (for randomised trials only), and links to full-text sources of the paper. In a random sample of 100 papers indexed on PEDro, 100% had one or more links to a full-text version online and 46% had at least one link to a free full-text version of the paper.

56 The developers of PEDro have studied how users search the database [11], which revealed several common errors. This has led to many improvements in the user interface to warn users when they are making a search error. For example, if a user tries to use brackets to group words as part of a free-text search string, they will receive a warning message to point out that brackets cannot be used in this way.

57 Another initiative in response to the study of how users search PEDro is the addition of a series of "how to" training videos to the PEDro Search Help page (https://www.pedro.org.au/italian/search-help/) to help users improve their search skills. These videos include how to: ask a clinical question in PICO format, perform a PEDro search, optimise searching, and access full-text copies of papers identified by the search. Most of these videos are available in 12 different languages, including Italian.

58 Each month, the details of any trials, reviews and guidelines that have just been added to the database can be emailed to you for free. Simply choose from 15 areas of practice (ie, the 10 subdisciplines of physiotherapy shown in Fig. 1 plus cerebral palsy, chronic pain, chronic respiratory disease, neurotrauma, or whiplash) and details of the new records related to your area(s) of interest will be automatically sent to the email address you nominate.

59 Some detailed studies of PEDro usage in individual countries (eg, Brazil [12], Japan [13]) have been conducted, which reveal interesting insights into regional disparities that may suggest different uptake of evidence-based practice by physiotherapists in different parts of those countries. A detailed regional analysis has not yet been conducted for Italy. However, some comments can be made about usage of PEDro in Italy.

60 Although usage fluctuates in all countries, Italy usually accounts for about 3% of worldwide usage of PEDro as judged by the number of searches. Italy usually ranks between 5th and 10th highest when countries are ranked by absolute number of searches. However, on a per-capita basis, Italy has lower usage than some larger countries (such as Brazil) and some smaller countries (such as Netherlands and Australia).

61 Since being launched in October 1999, PEDro has been used to answer 18,632,434 clinical questions [14]. The usage of PEDro has increased exponentially over time, as shown in Fig. 4. PEDro is now searched by users from virtually every country in the world, with an average of one search every 14 s. PEDro is increasingly searched as a source of trials for inclusion in systematic reviews.

62 SIF and its members make important contributions to PEDro. Along with 46 other physiotherapy associations and societies from around the world and other industry partners, SIF provides PEDro with some financial support. Collectively, these donations make it possible for PEDro to be kept up-to-date and freely available for the global physiotherapy community.

63 Through this partnership with PEDro, SIF encourages its members to enhance their skills in aspects of evidence-based practice and actively contribute to the indexing of evidence in PEDro. Approximately 40 SIF members have completed the PEDro Scale Training Program (https://training.pedro.org.au/). This online course develops skills in appraising the methodological quality of randomised controlled trials.

64 Many SIF members are "friends of PEDro", volunteering their time to rate trials using the PEDro Scale. The PEDro Scale scores displayed in PEDro are generated by teams of two or three raters, with two raters independently evaluating a trial and a third rater arbitrating any disagreements. In addition to rating the Italian-language trials indexed in PEDro (there were 53 Italian trials in the February 2019 update of PEDro), SIF members also rate trials in their area of clinical interest that are written in English

65 By supporting and collaborating with PEDro, SIF is doing a lot to encourage physiotherapists to undertake evidence-based practice. Italian physiotherapists should respond by taking the opportunity to use the Italian-language interface to access PEDro to improve their knowledge of available evidence about physiotherapy interventions. Italian physiotherapists can be proud of the work that SIF has done to facilitate evidence-based physiotherapy

66 Evidence-based practice involves the integration of the best research evidence with clinical expertise and patient values to make optimal health care decisions for individual patients.1 An evidence-based approach requires clinicians and researchers to be able to access the best evidence available quickly and easily.2 Advances in electronic technologies (eg, the Internet) and electronic bibliographic databases have facilitated access to information and made searching, locating, and retrieving evidence easier and less time-consuming for health care professionals, including physical therapists.

67 However, both practitioners asking clinical questions and researchers conducting exhaustive searches for systematic reviews experience several challenges when searching databases. Challenges encountered by clinicians can include limited access because of high subscription costs, rudimentary searching skills (so that searching may retrieve a large proportion of irrelevant literature and not identify key evidence), and time constraints

68 The databases differ with respect to primary professional target audience (eg, physicians, nurses, psychologists, physical therapists), journals indexed, and types of articles indexed (eg, all research articles or just randomized controlled trials and systematic reviews).4 Variations in indexing mean that a clinician may have more success in retrieving relevant literature by searching a specific database that comprehensively indexes particular types of research from the clinician's field.

69 In the present study, we sought to address this potential limitation by comparing the databases using an independent pool of trials generated from systematic reviews evaluating physical therapy interventions published in 2008 and indexed by PubMed. This strategy reduces the risk of selection bias because the link between the 2 databases (PEDro and CENTRAL) and PubMed is not as direct as the link with Cochrane reviews.Specifically, our objective was to compare the completeness of indexing of reports of randomized controlled trials of physical therapy interventions by 8 bibliographic databases

70 The reports of randomized controlled trials were eligible for inclusion if they met the following 4 criteria: the article was a full report published in a peer-reviewed journal, at least 2 interventions were compared (1 of these interventions could be a no-treatment control or a sham treatment), at least 1 of the interventions being evaluated was part of physical therapist practice,12 and the study involved random allocation or intended-to-be-random allocation of participants to interventions. These criteria were applied to focus the analysis on full reports of randomized controlled trials evaluating physical therapy interventions.

71 Seven of these databases were selected because they have been shown to be the most commonly used for systematic reviews of physical therapy interventions.9 Hooked on Evidence also was searched because it is an evidence resource developed specifically for physical therapists. These databases represent both subscription-only and open-access databases and both generic and physical therapy–specific databases. Two authors (Z.A.M. and A.M.M.) performed all searches using combinations of author names, words in the title, journal names, volume numbers, and page numbers

72 In contrast, we included trials from the reference lists of a random sample of systematic reviews of physical therapy interventions published in 2008 and indexed by PubMed, a strategy that decreased the link between the pool of trials and the databases under investigation. Although our strategy reduced the risk of selection bias, we acknowledge that several other sources of bias may affect the indexing of trials by bibliographic databases. These include language bias (trials with statistically significant results are more likely to be published in English-language journals),14 publication bias (research with statistically significant results is more likely to be submitted and published than research with nonsignificant findings

1) Les processus anatomiques qui suivent la section d'un tronc nerveux sont à la bas des troubles sensitivo-moteurs observés au début et des phénoménes de récupération motrice observés ensuite. Les lésions axonales secondaires à un traumatisme nerveux sont des trois types:

- la neuroapraxie: c'est la "sideration nerveuse", elle ne s'accompagne pas de lésion anatomique à proprement parler. C'est un trouble purement fonctionnel qui, spontanément, régresse en quelques semaines en général;

-l'axonotmésis: les cylindraxes sont interrompus, mais la gaine de Schwann est respectèe. Dans ce cas, le segment proximal proliférant va aisément retrouver la gaine de Schwann déshabitée du segment distal;

-la neurotmésis: c'est la section complète de tous les éléments de l'axone.

2) La rééducation respiratoire des bronchiteux chroniques comprend l'expectoration dirigée avant toute autre tentative et la ventilation dirigée s'il existe une insuffisance respiratoire manifeste. Parallèlement à ces deux progressions, il convient d'y ajouter celle de la rééducation respiratoire spécifique. Chaque technique de rééducation respiratoire peut etre analysée et chaque exercice codifiè. En pratique, le rééducateur dispose de diverses "progression" d'exercices dont le choix est fonction du but recherché. Lorsque l'indication de rééducation est posée, il convient d' établir pour chaque cas particulier un "plan de travail" qui comprend le plus souvent l'addition de pleusieurs progressions adaptées au cas particulier.

3) La rééducation fonctionnelle des cardiaques (opérés ou non) cherche à recouvrer la fonction cardio-respiratoire, rééquilibrée par un traitement médical ou chirurgical et à adapter les cardiaques à des activités physiques, compatibles avec les nouvelles possibilités de leur coeur. Le réentrainement progressif à l'effort prépare ces malades à se réadapter à une vie normale, familiale et professionnelle. La kinésithérapie se propose d'ameliorer la fonction cardio-respiratoire: en assurant une meilleure oxygénation par la rééducation de la fonction respiratoire; en favorisant le retour veineux à l'oreillette droite; en combattant l'anxiété des malades; en réadaptant à l'effort.

4) La kinésithérapie dans les traumatisés thoraciques agit d'abord sur la mécanique intérieure, en améliorant la ventilation, dans la mesure où elle facilite l'évacuation des sécrétions trachéo-bronchiques en assurant la liberté des voies aériennes. Ultérieurement elle restaure la fonction respiratoire en s'attaquant aux séquelles pleurales et diaphragmatiques. Elle agit ensuite sur la mécanique extérieure par les postures, la rééducation de la statique thoracique et par la remusculation. Elle cherche à garder la commande nerveuse des muscles ventilatoires par la rééducation active aidée précoce, puis à developper le tonus musculaire par le travail contre résistance. Enfin elle voudrait réentrainer les traumatisés thoraciques à l'effort.

5) La rééducation périnéale et pelvienne est une approche qui traite des dysfonctions du plancher pelvien comme l'incontinence, la descente d'organe, certains troubles de la sexualité ou encore les douleurs des régions pelvi-périnéale, ano-rectale et de la ceinture lombo-pelvienne. Le plancher pelvien est le groupe de muscles qui se situe à la base du bassin. Il supporte les organes pelviens et il permet de refermer les orifices comme l'urètre et l'anus afin de retenir l'urine, les selles et les gaz. Cependant, sa fonction ne se limite pas à cela. Il sert également à stabiliser le bassin auquel sont rattachés la colonne vertébrale et les membres inférieurs. Il occupe donc un rôle central dans le maintien d'une bonne posture.

6) Après un accident vasculaire cerebrale et l'apparition d'une lésion focale, même si le tissu nerveux sous-jacent meurt, il y a des chances de récupération grâce à la plasticité cérébrale qui se met en place. Grâce à des techniques de **neuroimagerie** par résonance magnétique (**IRM**) en statique (observation des lésions) ou en dynamique (suivi de l'activation des différentes régions du cerveau lors d'un mouvement), nous étudions dans quelle proportion les différents processus de plasticité cérébrale se mettent en place chez chaque patient : il peut y avoir une prise en charge de la fonction perdue par les tissus environnants, une participation à la commande d'un mouvement par les aires secondaires impliquées dans la programmation d'un mouvement ou encore une prise en charge par les aires controlatérales.

7) Après chirurgie de la hanche, la mobilisation progressive du membre atteint permet habituellement de récupérer la marche. La vitesse de la rééducation dépend partiellement du type de chirurgie effectuée. Par exemple, après une prothèse de hanche, la rééducation évolue habituellement plus rapidement. Idéalement, l'appui complet du poids corporel débute le 2e jour après l'intervention. Les exercices de marche sont démarrés du 4e au 8e jour (en supposant que les patients puissent supporter leur poids et s'équilibrer), et les exercices de montée d'escalier sont démarrés vers le 11e jour.