

1. Definizione e cause dell'anartria

Programmi riabilitativi della percezione uditiva nei bambini con impianto cocleare *Sara Settembrino*

2. Valutazione della deglutizione in pazienti con esiti di grave cerebrolesione

Modello sociale di afasia e terapia di gruppo *John*

3. Diagnosi differenziale tra afasia e aprassia del linguaggio

Valutazione e trattamento dell'amnesia globale post-traumatica *Alex per*

4. Riabilitazione del sistema del numero e del calcolo nell'adulto

Ruolo del logopedista nella valutazione del paziente in stato vegetativo protratto *Antonio*

5. Descrizione della manovra di Mendelshon

Criteri per definire l'emergenza dallo stato di minima coscienza *Stefano*



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6. Afasia trans corticale motoria

Marta Di Francesco

Prerequisiti per lo svezzamento dalla cannula tracheostomica

7. Fattori contestuali e gestione del paziente afasico

La rieducazione della funzione respiratoria

Elisabetta Primavera

8. Criteri diagnostici dell'afasia progressiva primaria

Algoritmi decisionali per lo svezzamento dalla cannula tracheostomica

9. Attività e partecipazione nei disturbi di apprendimento

L'afasia transcorticale sensoriale

10. Ruolo del logopedista nella rieducazione del paziente in stato minimamente cosciente

Funzione del muscolo interaritenoidico trasverso

Stefano

11. Disartria ipocinetica

Uscu

Quale parametro non viene valutato con la GIRBAS?



AUR LN mto

12. La riabilitazione del paziente con trauma cranico e deficit di memoria

Palpazione e manipolazione laringea

Deodato

13. La pragmatica del linguaggio

Azione della postura di compenso "capo ruotato verso il lato lesa" nel paziente disfagico

Toru Kasah

14. Modello cognitivo : il sistema semantico-lessicale

Azione della postura di compenso "capo flesso anteriormente" nel paziente disfagico

Jan

15. Terapia tubarica

Principali fase dello svezzamento dalla nutrizione enterale alla nutrizione orale del paziente disfagico

Angela Favetti



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01/03/11

16. Sintomatologia ed evoluzione dell'afasia progressiva primaria
Ruolo del logopedista nella valutazione del paziente in stato
minimamente cosciente

Man a terre Venturi

17. La realtà virtuale in logopedia
Il modello di produzione numerica: rappresentazione
semantica, sintattica e lessicale

R. H. L.

18. Relazioni semantico-lessicali e loro applicabilità clinica
Speech tracking nella terapia del paziente impiantato

Carlo Angelini

19. Lo svezzamento del paziente trachostomizzato
(decannulazione)
L'intervento del logopedista nei disordini dell'articolazione
temporomandibolare

Annalisa Di Bello

20. Il ruolo della working memory nella riabilitazione neuro
cognitiva
Malocclusioni e terapia miofunzionale

Giulia Dell'Orto

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21. Valutazione dei disturbi di coscienza
Disturbi della prosodia nella disartria post-traumatica

ee

22. Disturbi dell'attenzione nel cerebroleso adulto
Disartria ed aprassia verbale nell'adulto : diagnosi differenziale

AM

23. Valutazione del neglect extrapersonale e del neglect personale
Valutazione e rieducazione del paziente con aprassia ideativa

AM

24. Disordini delle funzioni attentive
Caratteristiche cliniche dell'afasia di conduzione

Lup. P. B. M.

25. Metodologie non verbali per migliorare le funzioni percettive,
attentive e cognitive
Descrizione della manovra di deglutizione super-sovraglottica

AM

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AM



1. L'acronimo RAM sta per? *Random Access Memory*

2. A cosa servono le unità disco?

Angelo Fanni

3. Dove si trova la scheda madre?

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

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

Elisabetta Pannofili

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

Full

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

8 Come si crea una cartella ?

9 Come si cambia il nome di un File ? *Shift*

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



Alt
Alt

11 Come si elimina un file ? *Talora Nochi*

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

13 Che tipo di computer è il notebook? *PC*

14 A cosa serve Outlook Express? *Per L*

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

16 Quali sono i tipi di allineamento dei paragrafi consentiti ?

Ultime Di Francesco

17 Cosa si visualizza Nella coda di stampa ? *per*

18 Che cos'è il desktop? *AM*

19 Che estensione hanno i file di Power Point? *PowerPoint*

20 Che estensione hanno i file di immagini?

Save Screens



AM LAM MBE K

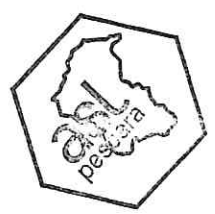
21. Cosa significa WWW? *www*

22. Che cos'è una homepage? *pagina*

23. A cosa serve il backup? *copiare file*

24. Che cos'è un pdf? *formato file*

25. Che cos'è un gigabyte? *1000 mb*



MB GB TB

1 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. *ee*

2 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. *Lym Pain*

3 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. *Triller*

4 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. *with*



ASL LHM

M.M.

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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).

Angelo Famula

6

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)

Deirdre [Signature]

7

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.

Teresa Beale

8

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 VO₂, exercise duration), HRQOL, adverse events (all-cause mortality, serious adverse events), and exercise rehabilitation protocol.

Kevin [Signature]



[Signature]

[Signature]

9 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

Elisabete Ramirez

10 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.

AG

11 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.

12 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.

fla

13 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.

SE

14 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.



AG
AIT
MRE
Caleb Chahal

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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.

Sopretten

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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.

Uberto Di Francesco

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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.

RLH

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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.

L h L

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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.

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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

Annalisa Di Santis



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21 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.

22 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.

23 *Family Pedro*

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.

24 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.

25 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

26 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.

