




































Brazilian practice guidelines for stroke rehabilitation: part II

Diretrizes brasileiras para reabilitação no acidente vascular cerebral: parte II

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Abstract

The Brazilian Practice Guidelines for Stroke Rehabilitation – Part II, developed by the Scientific Department of Neurological Rehabilitation of the Brazilian Academy of Neurology (Academia Brasileira de Neurologia, in Portuguese), focuses on specific rehabilitation techniques to aid recovery from impairment and disability after stroke. As in Part I, Part II is also based on recently available evidence from randomized controlled trials, systematic reviews, meta-analyses, and other guidelines. Part II covers disorders of communication, dysphagia, postural control and balance, ataxias, spasticity, upper limb rehabilitation, gait, cognition, unilateral spatial neglect, sensory impairments, home rehabilitation, medication adherence, palliative care, cerebrovascular events related to severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection, the future of stroke rehabilitation, and stroke websites to support patients and caregivers. Our goal is to provide health professionals with more recent knowledge and recommendations for better rehabilitation care after stroke.

Keywords

- ▶ Stroke
- ▶ Neurological Rehabilitation
- ▶ Health Planning Guidelines
- ▶ Practice Guidelines as a Topic

Resumo

As Diretrizes Brasileiras de Reabilitação do Acidente Vascular Cerebral (AVC) - Parte II, desenvolvida pelo Departamento Científico de Reabilitação Neurológica da Academia Brasileira de Neurologia é voltada para intervenções específicas de técnicas de reabilitação de déficits neurológicos e incapacidades. Seguindo o mesmo modelo da Parte I, a Parte II também se baseia em estudos randomizados, revisões sistemáticas, metanálises e outras diretrizes sobre o mesmo tema. A segunda parte aborda os distúrbios da comunicação, disfagia, controle postural e equilíbrio, ataxias, espasticidade, reabilitação do membro superior, marcha, cognição, negligência espacial unilateral, déficits sensoriais, reabilitação domiciliar, aderência ao uso de medicamentos, cuidados paliativos, o futuro da reabilitação no AVC, e *websites* de orientação sobre AVC para pacientes e cuidadores. Nosso objetivo é fornecer aos profissionais envolvidos na reabilitação conhecimento atualizado e recomendações para um melhor cuidado no pós-AVC.

Palavras-chave

- ▶ Acidente Vascular Cerebral
- ▶ Reabilitação Neurológica
- ▶ Diretrizes Para o Planejamento em Saúde
- ▶ Guias de Prática Clínica Como Assunto

INTRODUCTION

Stroke causes significant brain tissue damage and multiple neurological impairments, leading to a significant loss of function and residual disability.¹

The main goal of stroke rehabilitation is to organize and optimize the process of recovery, enabling a person to achieve their optimal physical, cognitive, communicative, emotional, and social levels of functioning through the integration of interdisciplinary rehabilitative techniques.²

In stroke recovery, it is necessary to consider the greater improvement that occurs in the first three months.³ During this phase, variable spontaneous neurological improvement can be considered a confounder in the assessment of the rehabilitation intervention.³ However, progress in functional outcomes after three months seems to be largely dependent on learning adaptation strategies.⁴ Improvement probably occurs through a complex combination of spontaneous recovery and learning-dependent processes, including restitution, substitution, and compensation.⁴ Neurological repair probably occurs through brain reorganization, leading to true recovery associated with compensation and restitution in the later phases after stroke.⁵ Active, functional, and independent movement contribute to the brain reorganiza-

tion after stroke and could be a key component in motor learning and rehabilitation.^{6,7}

The purpose of the Brazilian Practice Guidelines for Stroke Rehabilitation - Part II is to guide health professionals working in stroke rehabilitation with evidence from the most recent studies available. Brazilian versions of outcome measures used in stroke rehabilitation are presented in the **▶Supplementary Material**. The literature on interventions for each impairment and disability situation is presented, followed by practical recommendations. The classification of recommendation rating and level of evidence used in Part I was followed.⁸

The main challenge in developing this guideline was the heterogeneity and paucity of high-quality evidence to support intervention recommendations. Some meta-analyses of each intervention were based on low- or very low-quality evidence due to unclear or high risk of bias and the recruitment of small samples.⁷ Following the same methods used to write Part I, the members of the Scientific Department of Neurological Rehabilitation of the Brazilian Academy of Neurology participated in online discussion forums with predefined topics, followed by videoconference meetings in which controversies were discussed, leading to a consensus. For the preparation of the Brazilian Practice Guidelines for Stroke Rehabilitation, several national coauthors were

asked to write the suggested topics following criteria defined by the guideline coordinators. The present work focuses on recent clinical trials, meta-analyses, and systematic reviews in the literature on stroke rehabilitation.

RECOMMENDATION RATING AND LEVEL OF EVIDENCE

Recommendations

- Class I: There is evidence and/or consensus that the intervention is effective;
- Class II: There is conflicting evidence and/or divergence of opinions about the effectiveness and usefulness of the intervention:
 - IIa: Although there is divergent evidence on the usefulness and effectiveness of the intervention, the recommendations are in favor of the intervention;
 - IIb: Utility and effectiveness are less established by the evidence or opinions;
- Class III: There is evidence and/or consensus that the intervention is not useful or effective and may cause harm.

Level of evidence*

- A: Data are obtained from multiple randomized clinical trials.
- B: Data are obtained from a single randomized or non-randomized study.
- C: Consensus and expert opinions, case studies, or standart treatments.

* Recommendations of systematic reviews and meta-analyses based on very low- to low-quality evidence were classified as level “B” of evidence.

DISORDERS OF COMMUNICATION: APHASIA, DYSARTHRIA, AND APRAXIA OF SPEECH

The incidence of aphasia and dysarthria after a first stroke is of approximately 30% and 42% respectively.⁹ Regarding the survivors six months poststroke, 35% remain aphasic and 57%, dysarthric.⁹ The presence of apraxia of speech (AOS) alone is rare, co-occurring with aphasia in ~ 30% of the cases. Aphasia is associated with a longer hospital stay and greater mortality and morbidity. Disorders of aphasia, AOS, and dysarthria negatively impact the ability to work, lead to social withdrawal, and increase the risk of developing anxiety and depression.

Speech and language therapy is indicated for all patients with aphasia. A systematic review demonstrated that access to speech and language therapy benefits the functional use of language, language comprehension (listening or reading), and language production (speaking or writing) when compared with no access to therapy.¹⁰ Furthermore, functional communication was significantly better in people with aphasia submitted to therapy at a high intensity, high dose, or over a long period compared with those submitted to

therapy at a lower intensity, lower dose, or over a shorter period.¹⁰ There is a consensus that intervention should start early.¹⁰ However, a recent prospective, randomized, single-blinded trial¹¹ aimed to determine whether intensive aphasia therapy, beginning within 14 days after stroke, improved communication recovery. The authors¹¹ found that early, intensive aphasia therapy did not improve communication recovery within 12 weeks poststroke compared with usual care. However, they¹¹ pointed out that most participants, regardless of group allocation, achieved significant clinical gains in language recovery.

Regarding AOS, the articulatory–kinematic approach is the most used, studied, and recommended to improve speech sound accuracy.¹² Speech therapy also positively affects the recovery of patients with dysarthria.¹³ A meta-analysis¹⁴ of patients with poststroke dysarthria showed that the alternating and sequential motion rate and maximum phonation time improved significantly after speech rehabilitation.

The evidence that repetitive transcranial magnetic stimulation (rTMS) with transcranial direct current stimulation (tDCS) is effective in the treatment of aphasia is of low to moderate quality.^{15–19} Low frequency rTMS applied over the right inferior frontal gyrus is probably effective in promoting the recovery of non-fluent aphasics in the chronic stage of stroke, especially if used in combination with speech and language therapy.²⁰ Anodal tDCS applied over the left inferior frontal gyrus is supported by evidence of moderate quality for its efficacy in the naming of nouns, but not verbs, in non-fluent aphasics in the chronic phases of stroke, with possible maintenance of gains during follow-up.²⁰ Few studies on apraxia of speech and dysarthria have been conducted, and those available only involve small samples.

The positive results reported in meta-analyses and systematic reviews do not necessarily reflect meaningful clinical benefits.¹⁵ Differences in the methodologies employed to analyze study data lead to different levels of evidence.¹⁵ Patient responses to stimuli vary greatly due to individual factors and different mechanisms of functional reorganization of the brain following stroke, which are poorly understood.¹⁹ The strategy of applying inhibitory or excitatory stimuli to the left or right hemispheres may not be the optimal approach, and the best site and paradigm for stimulation must first be determined.¹⁶ The evidence supporting the benefits of rTMS and tDCS is preliminary, and there is no consensus on the therapeutic use of these techniques in the clinical practice.^{16–19}

Regarding the pharmacological approach, donepezil and memantine have been shown to improve several aspects of language;²¹ the effects of galantamine, amphetamines, and levodopa remain inconclusive; bromocriptine demonstrated no benefits,²¹ whereas piracetam promoted a transient limited effect.²²

Recommendations

- Speech and language therapy should be started early for all poststroke patients with aphasia (Recommendation I-A);

- The effectiveness of combined early and intensive aphasia therapy is uncertain (Recommendation IIb-A);
- For AOS, an articulatory–kinematic approach is recommended (Recommendation IIa-A);
- Speech therapy is indicated for dysarthria rehabilitation (Recommendation IIa-A);
- The benefits of rTMS and tDCS in poststroke aphasia rehabilitation are uncertain (Recommendation IIb-A), as well as in AOS and dysarthria rehabilitation (Recommendation IIb-C);
- Donepezil and memantine can be used for poststroke aphasia treatment (Recommendation IIa-A);
- There are no recommendations for the use of piracetam, bromocriptine, galantamine, levodopa, or amphetamines (Recommendation III-A).

DYSPHAGIA

Dysphagia occurs in 65% to 90% of stroke patients and is associated with aspiration pneumonia, dehydration, malnutrition, and increased mortality.²³ Although spontaneous recovery from dysphagia occurs in stroke patients, 11% to 50% will have permanent dysphagia up to 6 months after the stroke, increasing the risk of pneumonia 3-fold. In poststroke patients with laryngotracheal aspiration, pneumonia is eight times higher.²³

Dysphagia screening should be performed early, and bedside evaluation can provide valuable information.²⁴ However, bedside evaluation alone cannot detect aspiration without clinical signs.²⁵ If silent aspirations are suspected, videofluoroscopy and fiberoptic endoscopic evaluations are appropriate methods to evaluate the swallowing mechanism.^{26,27}

Rehabilitation of dysphagia in stroke patients is based on the concept of neuroplasticity; it involves compensatory strategies and modification of the physiology of swallowing. Compensatory strategies include volume and texture modifications and postural techniques such as a chin tuck position.²⁸ Some maneuvers may serve as a compensatory strategy and function as rehabilitative exercises, such as the effortful swallow, supraglottic swallow, super-supraglottic swallow, and the Mendelsohn maneuver.²⁸ Other exercises, such as the Shaker exercise and Masako maneuver, may improve swallowing physiology. Tactile, thermal, or sour taste stimulation and noninvasive neurostimulation therapies are also used.²⁸

Swallowing therapies in survivors up to six months after stroke may reduce the length of hospital stay, dysphagia, chest infections, and swallowing ability.²⁸ However, they do not significantly affect mortality, dependency/disability, and case fatality outcomes.²⁸

A randomized trial²⁹ demonstrated significant recovery from dysphagia, prevention of aspiration pneumonia, and reduced time to return to oral feeding in participants who initiated swallowing therapy in the first 48 hours and during the first 3 days compared with a delayed dysphagia program in rehabilitation.

Non-invasive neurostimulation therapies, such as rTMS, tDCS, and surface neuromuscular electrical stimulation pro-

vide benefits regarding performance in heterogeneous swallowing tests.^{30,31} However, the number and quality of the studies were relatively limited. Statistical heterogeneity was moderate, high, or not reported in some of the published meta-analyses^{30,31} about the effects of these interventions in post-stroke dysphagia. Phase-3 clinical trials are required. There is no benefit with pharyngeal electrical stimulation.³²

Recommendations

- Early swallowing therapies are recommended for recovery from dysphagia (Recommendation I-A);
- Dysphagia screening should be performed early after stroke to prevent aspiration pneumonia, malnutrition, and dehydration (Recommendation I-B);
- Surface neuromuscular electrical stimulation, rTMS, and tDCS are under investigation, but evidence about their clinical effectiveness is not well established (Recommendation IIb-A);
- Videofluoroscopy and fiberoptic endoscopic evaluations can be performed if aspiration is suspected without clinical symptoms or signs (Recommendation IIa-B);
- Pharyngeal electrical stimulation is not recommended to improve dysphagia after stroke (Recommendation III-A).

POSTURAL CONTROL AND BALANCE

Changes in balance and postural control are caused by motor impairment and loss of sensory and spatial orientation of the body. They are common after stroke and negatively affect the quality of life, activities, and participation of individuals.³³

Trunk training, with support, on unstable surfaces, such as balls used in physical therapy sessions, air mattresses, pillows, and boards, appears to be superior to stable surfaces to improve static and dynamic balances.³⁴ There is strong evidence of the benefits of trunk control training in sitting as well as mobile and static balances.³⁵

Two systematic reviews with meta-analyses showed that virtual reality on its own³⁶ and virtual reality associated with conventional physiotherapy³⁷ effectively improved post-stroke balance. Despite limited evidence, telerehabilitation, combined with virtual reality, for balance training, can be an alternative to overcome difficulty in accessing a rehabilitation service.³⁸

Hydrotherapy significantly improved postural balance, more so in chronic patients than in patients in the subacute phase.³⁹ Aerobic exercise on a cycle ergometer has no positive effect on balance.⁴⁰ However, the effects of treadmill gait training, with or without weight support, have been found to be positive.⁴¹ Peripheral somatosensory stimulation was beneficial in controlling postural stability in individuals in the poststroke chronic phase as an adjuvant therapy.⁴² A meta-analysis⁴³ showed that robot-assisted gait training improved balance when compared with the absence of this intervention, despite the limitations of the analyzed studies.

The effects of mental imagery, rTMS, and tDCS are controversial due to the methodological variability in the studies.^{44–46}

Functional task-training associated with musculoskeletal intervention and/or cardiopulmonary intervention and sensory interventions seem to be effective in improving balance and postural stability respectively.⁴⁷ However, the heterogeneity of physical therapy and the weak methodological quality of studies limited the interpretation and the confidence in findings.⁴⁷ The physical therapy techniques evaluated in this meta-analysis⁴⁷ included balance training, walking, transfers, getting up and down activities, reaching objects with upper limbs (ULs), active muscle strengthening, active-assisted and passive cardiopulmonary fitness, and sensory interventions such as thermal, tactile, visual, and vestibular stimulation.

Recommendations

- Training with specific exercises for balance, on different surfaces, unilateral weight bearing, and gait training are recommended (Recommendation I-A);
- Methods using hydrotherapy and aquatic exercises are recommended (Recommendation I-A);
- Virtual reality is recommended to improve poststroke balance (Recommendation I-A);
- Task-specific physiotherapy techniques associated with interventions for cardiovascular conditioning, skeletal muscle, and sensory stimulation should be employed (Recommendation IIa-A);
- Treadmill training, with or without partial weight bearing, and robot-assisted gait training should be used (Recommendation IIa-A);
- Peripheral somatosensory stimulation may be used as an adjuvant therapy (Recommendation IIb-B);
- The mental practice technique is controversial (Recommendation IIb-B);
- The effects of tDCS and rTMS are uncertain (Recommendation IIb-A);
- Aerobic exercises on a cycle ergometer, for balance improvement and postural control, are not effective (Recommendation III-A).

ATAXIAS

The term ataxia refers to a disturbance in voluntary movement present in cases of injury or damage to the cerebellum, cerebellar peduncle, and cerebellar pathways of the brainstem.⁴⁸ Ataxia, present in 2% to 3% of patients after stroke, is a loss of coordination, dysmetria, dysarthria, hypotonia, rebound phenomenon, and nystagmus.⁴⁹

There are few intervention studies on ataxia in stroke patients. Case studies indicate that task training with specific goals can improve limb ataxia in poststroke individuals, and rTMS is still in the experimental phase.⁵⁰

Recommendations

- Task training, with specific goals, can be used in poststroke ataxia (Recommendation IIb-C);
- Repetitive transcranial magnetic stimulation is still in the experimental phase and should not be routinely

used in the treatment of post-stroke ataxia (Recommendation III-C).

SPASTICITY

The prevalence of poststroke spasticity (PSS) ranges from 20% to 40%.⁵¹ Loss of movement control, abnormal posture, increased muscle tone, painful spasms, and an overall decline in muscle function are the main symptoms.⁵¹ Changes in the passive properties of muscles may lead to contractures.⁵¹

The clinical assessment methods most commonly used include the Modified Ashworth Scale (MAS) and the Modified Tardieu Scale (MTS).⁵²

A combination of rehabilitation techniques and pharmacological and non-pharmacological interventions produces better effects.⁵³

Baclofen, tizanidine, and oral benzodiazepines, which are commonly used in daily practice, still lack good evidence for their use, with frequent adverse effects, especially in elderly patients.⁵⁴

There is sufficient evidence to conclude that botulinum toxin is safe and effective in reducing UL and lower-limb spasticity after stroke.⁵⁵ However, the effect on motor function remains unclear.⁵⁶ A meta-analysis⁵⁷ showed improvement in impairment, but no significant effect on gait speed. A recent consensus of specialists⁵⁸ in the treatment of poststroke spasticity with botulinum toxin recommended an approach based on three key areas: individualized intervention, optimal injection technique and preparation of the toxin, and rehabilitation with adjuvant therapies concomitant with and after the injection of botulinum toxin.

Severe forms of PSS can be treated with intrathecal baclofen.⁵⁹

Among the non-pharmacological approaches, kinesiotherapy⁶⁰ and functional bandaging (taping)⁶¹ can be considered. Splints and orthoses have uncertain benefits.⁶² Transcutaneous electrical nerve stimulation (TENS) and functional electrical stimulation (FES) reduce spasticity in the lower limbs.^{63,64} Acupuncture and electroacupuncture combined with conventional routine care may be beneficial for PSS.⁶⁵

Recommendations

- The application of botulinum toxin to target muscles is recommended for the treatment of spasticity (Recommendation I-A);
- Transcutaneous electrical nerve stimulation is recommended to reduce muscle spasticity in the lower limbs (Recommendation I-A);
- Functional electrical stimulation of spastic muscles can be considered (Recommendation IIa-A);
- Treatment with intrathecal baclofen can be used in refractory cases (Recommendation IIa-A);
- Acupuncture, electroacupuncture, and functional bandaging should be considered (Recommendation IIa-A);
- Kinesiotherapy may be considered in the treatment of spasticity (Recommendation IIb-B);

- Oral medications such as baclofen, tizanidine, and benzodiazepines may be used, always considering their adverse effects (Recommendation IIb-A);
- The effects of botulinum toxin on function are uncertain (Recommendation IIb-A);
- Splints and positioning orthoses have uncertain effects (Recommendation IIb-A).

UPPER LIMB

The UL is affected in 80% and 40% of patients in the acute and chronic phases after stroke respectively.⁶⁶ Impairments of the UL chronically limit functional independence and satisfaction in 50% to 70% of stroke patients. Weakness, hypotonia, hypertonia, joint instability, and loss of motor control cause functional limitations in reaching, grasping, and manipulating objects.⁶⁶

Although extensively used in rehabilitation, there is limited evidence favoring the Bobath approach.⁶⁷ Strength training can improve UL strength and function without increasing tone or pain.⁶⁸ Resistance training is superior to other therapies for muscular strength and motor function.⁶⁹ There is no evidence that stretching therapy improves UL motor impairment and disability.⁶⁶

Although a previous meta-analysis suggested that constraint-induced movement therapy (CIMT) might be superior to traditional rehabilitation, the most recent Cochrane review⁷⁰ indicated that CIMT was associated with limited improvement in motor impairment and function, but these benefits did not reduce disability. However, another meta-analysis⁷¹ showed significant benefits of CIMT in patients with acute or subacute stroke.

Biofeedback may have some beneficial impact, according to low-quality evidence.⁷² There is evidence of the effectiveness of mirror therapy in improving upper extremity motor function, motor impairment, activities of daily living, and pain,⁷³ in association with other conventional rehabilitation therapies for stroke patients.⁷⁴ Mental practice (MP) effectively reduces the limitations to UL activity after stroke, particularly in the first three months and in individuals with severe UL dysfunction.⁷⁵ Bilateral and unilateral UL training improved motor impairment and functional performance after stroke; however, bilateral training was superior in terms of improving motor impairment.⁷⁶

Although some studies have shown positive effects with repetitive peripheral sensory stimulation (RPSS),⁷⁷ tDCS,⁷⁸ and rTMS,⁷⁹ these techniques are still under investigation.

When initiated within two months of the stroke, FES is a promising therapy for UL recovery.⁸⁰ However, the very low quality of the evidence analyzed means that a clear conclusion about its effects cannot be established. Robot-assisted therapy promotes the use of the affected limb, intensifies rehabilitation through task repetition, and offers task-specific practice.⁸¹ Virtual reality (VR) provides augmented feedback and preserves motivation.⁸² A common denominator of VR systems and robot-assisted therapy is playful intervention by means of serious games.⁸³ A serious game is defined as a game that has education or rehabilitation as its

primary goal.⁸⁴ These games combine entertainment, attentional engagement, and problem solving to challenge function and performance.⁸⁴ After a case of stroke, VR for the UL appears to be more effective than the conventional methods,⁸⁵ and it may be beneficial when used as an adjunct to usual care. Upper-limb rehabilitation through serious games showed more improvement when compared with the conventional treatment, and long-term effect retention was maintained for UL function, but heterogeneity was high.⁸⁶ Robot-assisted therapy might be superior to conventional rehabilitation in improving severe UL motor impairment in stroke patients with hemiplegia and limited potential for spontaneous recovery.⁸⁷

There is insufficient evidence to support the efficacy of methylphenidate, trazodone, levodopa, and nortriptyline in UL recovery after stroke.⁶⁶ Fluoxetine for six months did not improve functional outcomes and increased the risk of bone fractures.^{88,89} Although not specific to UL, a recent guideline presented a weak recommendation for cerebrolysin (30 mL intravenously for at least ten days) and citalopram (20 mg) to promote early motor neurorehabilitation after acute ischemic stroke.⁹⁰

Recommendations

- Techniques to strengthen the UL are recommended to improve UL recovery after stroke (Recommendation I-A);
- Mirror therapy, MP, and unilateral and bilateral training for UL rehabilitation after stroke can be beneficial (Recommendation IIa-B);
- Virtual reality should be considered an adjuvant therapy for UL recovery after stroke (Recommendation IIa-B);
- Serious games can be useful in UL rehabilitation after stroke (Recommendation IIa-B);
- Robot-assisted therapy can be indicated in severe UL motor impairment poststroke (Recommendation IIa-A);
- Constraint-induced movement therapy can be used in UL rehabilitation after stroke (Recommendation IIa-A);
- Biofeedback can be useful for UL recovery after stroke (Recommendation IIa-B);
- The effect of stretching therapy is not well established (Recommendation IIb-B);
- The effectiveness of FES for UL improvement after stroke is unclear (Recommendation IIb-B);
- Repetitive peripheral sensory stimulation, tDCS, and rTMS for UL rehabilitation are under investigation, but evidence about their clinical effectiveness is not well established (Recommendation IIb-A);
- The benefits of the Bobath approach are uncertain (Recommendation IIb-C);
- Cerebrolysin and citalopram may be considered in early motor rehabilitation after acute ischemic stroke (Recommendation IIb-A);
- Methylphenidate, trazodone, levodopa, and nortriptyline are not recommended to enhance UL recovery after stroke (Recommendation III-B);
- Fluoxetine should not be used for motor rehabilitation (Recommendation III-A).

MOBILITY

Limitations to mobility and activities related to gait are some of the most impacting sequelae of stroke. More than 20% of stroke survivors do not walk independently, and even if they achieve independence, most have difficulty ambulating in their communities.⁹¹

An exercise program that combines cardiorespiratory training, to enhance cardiorespiratory fitness, and resistance training could promote greater walking speed, muscle strength, balance, and walking endurance.⁹²

Circuit class therapy (CCT) is superior to conventional therapy in improving mobility, independence, and gait speed in stroke patients.⁹³ The potential risk of falls should be considered.⁹³

Rhythmic auditory cueing enhances gait performance, dynamic postural stability, stride length, and cadence.⁹⁴

Water-based exercises may improve muscle strength, balance, mobility, and aerobic capacity compared with land-based exercises.⁹⁵

Improvement in the ability to walk independently with treadmill training (TT), with or without body weight support, was not superior when compared with no TT, but walking speed and walking endurance improved slightly in the short term.⁹⁶ The effects were more significant, though not persistent, for those who were able to walk.⁹⁶ Better recovery of walking speed and distance in ambulatory patients was observed with TT.⁹⁷

Gait in electromechanical-assisted training associated with physiotherapy after stroke promotes a greater chance of achieving independent walking than physiotherapy without these devices.⁹⁸ Three months after stroke, participants who were not ambulatory seemed to benefit most from this type of intervention.⁹⁹ Repetitive gait training within the first three months poststroke can lead to long-term functional improvements if provided with an end-effector robot.¹⁰⁰

When compared with conventional therapy approaches, VR and interactive game training did not produce statistically significant changes in regarding improvements in gait speed or balance.⁸⁵

Compared with placebo or no intervention, there is no evidence of superiority in gait, motor function, and functional mobility after stroke from motor imagery.¹⁰¹

The Bobath approach was not superior in terms of regaining mobility, motor control of the lower limb and gait, balance, and activities of daily living of poststroke patients when compared with other interventions.⁶⁷

No differences in motor function were observed between real acupuncture and sham acupuncture after stroke.¹⁰²

Stroke patients may require an assistive technology device to aid in mobility. These comprise orthoses, splints, wheelchairs, walkers, and crutches.

Ankle-foot orthosis (AFO) is recommended to position the ankle during gait to prevent foot drop injury and to improve gait kinetics and kinematics of both the knee and ankle joints in poststroke gait.¹⁰³ There are two AFO models: fixed AFOs are recommended for patients who demonstrate great ankle

instability during gait, and articulated AFOs are indicated for patients with greater stability of the ankle joint.^{104,105} The AFO can improve ankle and knee kinematics, kinetics, and the energy cost of walking in stroke survivors.¹⁰⁴ However, no convincing evidence has been observed regarding walking speed.¹⁰⁵ A decrease in energy expenditure during gait with AFO was also observed.¹⁰⁶

Ankle joint stabilization improves with FES of the foot dorsiflexors.¹⁰⁷ It consists of a structure with different presentations in which plantar sensors are connected to superficial electrodes that promote the contraction of the tibial and dorsiflexor muscles, preventing foot drop during the swing phase of gait.¹⁰⁷ A meta-analysis¹⁰⁸ concluded that there was evidence that AFO and FES can increase gait speed, mobility, dynamic balance, quality of life, endurance, and muscle activation poststroke. Another meta-analysis¹⁰⁹ of low-quality evidence showed that FES applied to the paretic peroneal nerve, when combined with physiotherapy, can improve ankle dorsiflexion, balance, and functional mobility.

The benefits of walking with a cane poststroke are uncertain. A comparative study of the effect of a simple cane and a four-point cane in individuals three months after a stroke showed that the use of a cane improves gait symmetry, which is indicated for patients at the beginning of gait training.¹¹⁰ However, despite the methodological limitations of the studies, a systematic review¹¹¹ showed no improvement in gait parameters concerning speed, step length, cadence, and symmetry after stroke with a single support cane. There was a slight reduction in speed with a four-point cane compared with the gait without a mobility device.¹¹²

Walkers can help gait in patients with balance deficits, but weakness in the UL or the inability to use the hand to grasp the walker is a limitation to their use. When comparing the use of a simple cane with a four-point cane and walkers, it was observed that the energy spent in gait in individuals who used a walker was higher.¹¹³

Mobility devices such as wheelchairs, walking sticks, and bath chairs are associated with greater independence after a stroke.¹¹³

Recommendations

- An exercise program, including cardiorespiratory and resistance training, should be used to improve gait after stroke (Recommendation I-A);
- Circuit class training is recommended for walking and balance recovery poststroke (Recommendation I-A);
- Functional electrical stimulation can be useful in improving ankle dorsiflexion, balance, and functional mobility (Recommendation IIa-B);
- It is reasonable to use AFO in gait rehabilitation after stroke (Recommendation IIa-A);
- Gait performance, dynamic postural stability, stride length, and cadence can be improved with rhythmic auditory cueing (Recommendation IIa-A);
- Water-based exercises can be recommended for gait rehabilitation after stroke (Recommendation IIa-B);

- Treadmill training, with or without body weight support, can improve speed and walking endurance poststroke, and is reasonable to use (Recommendation IIa-B);
- Electromechanical-assisted gait added to physiotherapy can be beneficial for gait recovery, mainly in the first three months poststroke, and for participants who are not able to walk. (Recommendation IIa-B);
- The benefits of VR, interactive games, mental imagery, and the Bobath approach are not well established (Recommendation IIb-A);
- Ankle-foot orthoses can be used in patients with poststroke foot drop (Recommendation IIa-A);
- Functional electrical stimulation of the dorsiflexor muscles should be considered to improve gait and ankle positioning (Recommendation IIa-A);
- Wheelchairs can be used to promote greater levels of independence after a stroke (Recommendation IIa-C);
- The benefits of walking devices and canes to support gait after stroke are uncertain (Recommendations IIb-B);
- Acupuncture is not useful for gait recovery after stroke (Recommendation III-A).

COGNITION

Poststroke cognitive deficits occur early and are quite frequent, as they appear within the first 3 months in up to 55% of patients when at least 1 cognitive domain is considered.¹¹⁴ Poststroke dementia occurs when there is cognitive decline immediately after or within the first six months after vascular ictus, with no evidence of improvement in this period.¹¹⁵ Since an informal clinical evaluation may underdiagnose cognitive decline, the use of test that have already been validated is recommended.¹¹⁶ No superiority was observed among the tests that assess cognition.¹¹⁷

Reducing the levels of systolic blood pressure is effective in decreasing the incidence of poststroke cognitive deficit.¹¹⁸ The use of statins shows conflicting results.¹¹⁹ Donepezil and galantamine may be useful to improve poststroke cognition, but the benefits of memantine and rivastigmine are not well established.¹²⁰

Evidence¹²¹ suggests that physical activity is an intervention with a protective role that may improve poststroke cognition. In addition, it is a low-cost strategy with a positive impact on motor function, quality of life, and cardiopulmonary condition.¹²²

Cognitive rehabilitation has shown benefits, improving poststroke memory and attention, but with limited conclusions regarding its efficacy due to the quality of the studies published.¹²³ The association between cognitive and physical rehabilitation seems to provide greater benefits than isolated therapies.¹²⁴ Studies¹²⁵ with VR are isolated, but show promising results. A meta-analysis¹²⁶ of four systematic reviews on poststroke cognitive impairments showed that acupuncture is safe and improves cognitive function without serious adverse events in stroke patients.

Repetitive transcranial magnetic stimulation and tDCS are still in an exploratory stage.¹²⁷ There is no evidence to

recommend neurofeedback in poststroke cognitive rehabilitation because of the limitations of the studies evaluated.¹²⁸

Recommendations

- Cognition assessment poststroke with validated tests is recommended (Recommendation I-B);
- Systolic pressure reduction is recommended to prevent poststroke cognitive deficits (Recommendation I-A);
- Acupuncture associated with cognitive rehabilitation can be employed (Recommendation IIa-A);
- Physical activity should be employed as an adjunctive treatment in the rehabilitation of poststroke cognitive deficits (Recommendation I-A);
- Donepezil and galantamine may be beneficial for patients with poststroke mixed dementia (Recommendation IIa-A);
- The association of cognitive rehabilitation with physical rehabilitation may be beneficial (Recommendation IIa-C);
- The benefits of memantine and rivastigmine have not been established (Recommendation IIb-A);
- Cognitive rehabilitation strategies for memory may be used, but the benefits are uncertain (Recommendation IIb-C);
- Neuromodulation and neurofeedback techniques are still under investigation, and should not be used routinely (Recommendation III-C).

UNILATERAL SPATIAL NEGLECT

The non-recognition of space, usually on one side of the body, or of any stimulus applied to it, is called hemineglect syndrome or unilateral spatial neglect (USN),¹²⁹ and it designates a consistent, exaggerated spatial asymmetry in processing information in bodily and/or extrabodily space due to an acquired cerebral lesion, which cannot be explained by primary motor or sensory deficits. The processing of neglected information can occur implicitly, without reaching consciousness, and can influence task performance.¹²⁹

Unilateral space neglect occurs in ~ 50% of individuals after right-hemisphere stroke, and it may persist in 75%, with some symptoms, in the chronic phase.¹³⁰ Patients with neglect are often unaware of or fail to acknowledge items on their contralesional side and attend instead to items on the same side as their brain damage—their ipsilesional side.¹³⁰ Unilateral space neglect causes prolonged hospitalization, impaired functional recovery, and reduced quality of life.¹³¹

Several rehabilitation methods have been developed to improve spatial neglect in the last few decades. These can be classified according to their theoretical basis:¹³² 1) enhancing awareness of neglect behavior through a top-down mechanism; 2) low-level bottom-up sensory stimulation; and 3) neuromodulation.

Top-down treatments consist of training the gaze direction using cues from the patient's left side. Videos to show the patient their omissions during recorded functional tasks and mental images can also be used. However, these methods

are limited because they require attention skills, which can be hampered by the lack of awareness of spatial neglect behaviors, such as anosognosia.¹³²

Bottom-up treatments, including prismatic adaptation, visual scanning training, optokinetic stimulation, VR, limb activation, neck vibration combined with prism adaptation, voluntary trunk rotation, and vestibular rehabilitation improve immediate and long-term performance in USN.^{132,133}

Moderate-quality evidence showed that rTMS was more efficient than sham for USN after stroke.¹³⁴ Repetitive transcranial magnetic stimulation in the posterior parietal cortex, and theta-burst stimulation, improved USN after stroke.¹³⁵ Very low-quality evidence suggested that tDCS has a beneficial effect in improving USN after stroke.¹³⁶

Recommendations

- Repeated “top-down” and “bottom-up” interventions can be considered, such as prismatic adaptation, visual scanning training, optokinetic stimulation, VR, limb activation, motor imagery, voluntary trunk rotation, vestibular rehabilitation, and vibration of the neck combined with prismatic adaptation to improve USN after stroke (Recommendation IIa-A);
- The benefits of tDCS and rTMS to reduce USN after stroke are uncertain (Recommendation IIb-A).

SENSORY IMPAIRMENT (HEARING, VISION, AND TOUCH)

Sensory impairment after stroke, including hearing, vision, touch, and proprioception, is directly linked to activity limitations and participation restrictions.¹³⁷ However, they can improve with therapeutic intervention, particularly multimodal interventions.¹³⁸

Hearing loss of a vascular cause is usually associated with cerebellar infarction in the territory of the anterior inferior cerebellar artery.¹³⁹ The incidence of hearing loss in stroke patients is twice as high as that of non-stroke individuals, and it can limit participation in rehabilitation programs.¹⁴⁰

Approximately 20% of stroke survivors report severe difficulties with speech recognition in the presence of background noise, despite normal audiometry.¹⁴¹ Hearing loss is usually treated with a personal frequency-modulated (FM) system with meaningful benefits.¹⁴² A prospective, nonrandomized, controlled study in stroke patients showed clinical improvements in the speech reception threshold with the use of a personal FM system.¹⁴³

Visual impairment after stroke has a prevalence of 73% in the acute stroke population.¹⁴⁴ The four most impaired visual functions are reduced central vision, loss of the peripheral visual field, eye movement disorders, and visual perception disorders.¹⁴⁵

For the treatment of visual loss, prism lenses, unilateral eye occlusion, adapted lighting, picture amplification, environment modification, orthoptic exercises, Fresnel prism, verbal, written, and head posture advice have been employed.¹⁴⁶ The evidence for all these interventions is

weak, and there is a lack of evidence relating to their effect on functional ability in activities of daily living.¹⁴⁶

One in two individuals who had a stroke had reduced sensation, impacting both the ability to function independently and the overall quality of life.¹⁴⁷ In acute ischemic stroke, almost 60% of patients showed somatosensory impairment in at least one subitem in the acute stage, but there is considerable recovery over time. Reduced sensation is associated with reduced motor function in terms of quality of movement control, and lesser rehabilitation outcomes.¹⁴⁸

Sensory rehabilitation, which triggers the activation of the cutaneous nerves, can be performed with somatosensory afferents, such as thermal, pressure, peripheral nerve, transcutaneous electrical nerve, and vibration stimulations.¹⁴⁹ Additionally, a sensory retraining approach based on graded re-education using learning principles and augmenting sensory input, such as proprioception, tactile recognition, desensitization, stereognosis, location, and discrimination is another option for sensory stimulation. Additionally, with haptic-based augmented reality, feedback devices that augment targeted sensory afferents can be used.¹⁴⁹

Systematic reviews and meta-analyses have shown that a varied range of intervention methods intended for retraining leg somatosensory function after stroke effectively improves somatosensory impairment and balance, but not gait.¹⁵⁰ A systematic review showed that somatosensory retraining may assist people in regaining somatosensory discrimination skills in the arm after stroke.¹⁵¹

Recommendations

- Frequency-modulated systems are recommended for hearing loss after stroke (Recommendation I-B);
- Leg somatosensory retraining can be used to improve balance after stroke (Recommendation IIa-A);
- Arm somatosensory retraining can improve somatosensory discrimination skills after stroke (Recommendation IIa-A);
- Prism lenses, unilateral eye occlusion, adapted lighting, picture amplification, environment modification, orthoptic exercises, Fresnel prism, verbal, written, and head posture advice may be used for visual impairment after stroke (Recommendation IIb-C).

REHABILITATION CONTINUITY: HOME REHABILITATION, RETURN TO LEISURE, WORK, AND DRIVING

Home rehabilitation (HR) should be part of the ongoing rehabilitation planning, according to a meta-analysis.¹⁵² Well-established and early HR resulted in a better quality of life.¹⁵²

Resistive reach and grip exercises in the home environment showed positive results in the activity level of the ULs.¹⁵³ Home mirror therapy associated with repetition training and activities of daily living can result in better responses in motor activity and in the sit-and-stand test.¹⁵⁴ Visuomotor feedback training at home was an effective method to improve USN.¹⁵⁵ In poststroke home treatment,

VR was beneficial for UL mobility.¹⁵⁶ Home rehabilitation with glove therapy and fingertip sensors with visual feedback on a screen according to the movements performed improved hand movement compared with conventional treatment in HR.¹⁵⁷ Home caregivers promoted positive results for poststroke physical function and depressive symptoms.¹⁵⁸

Stroke patients have been shown to have difficulties participating in leisure and recreational activities.¹⁵² Recreational activity programs improved physical and mental function.¹⁵⁹

Less than 50% of poststroke patients can return to work 6 months post-stroke and 50% have deficiencies in performing work activities 5 years after the event.¹⁶⁰ Intervention in the work environment promoted a higher percentage of return to work.¹⁶⁰ Occupational rehabilitation interventions have shown positive effects on accommodation to the environment and job satisfaction.¹⁶¹

After a stroke, drivers may have compromised reflexes, leading to risks behind the wheel, with a consequent increase in the chances of collisions, excessive speed, and invasion of the opposite lane.¹⁶² Although the effects of rehabilitation on poststroke return to steering are uncertain, the use of a rotary knob in steering in a specific position and driving simulators can be used as tools for a return to driving activity after stroke.¹⁶³

Recommendations

- Early planned HR is recommended for poststroke recovery (Recommendation I-A);
- Resistance exercises involving reaching and gripping with the ULs should be included in the HR (Recommendation I-A);
- It is recommended that caregivers be educated to help patients' physical and emotional recovery at home (Recommendation I-A);
- The combination of rehabilitation with mirror therapy and specific training can be used in HR (Recommendation IIa-B);
- Virtual reality and gloves with sensors on the fingers associated with visual feedback can be used in HR (Recommendation IIa-B);
- Poststroke patients should receive guidelines for recreational activities (Recommendation IIa-B);
- Interventions in the workplace must be available to facilitate poststroke return to work (Recommendation IIa-B);
- Adaptations in motor vehicles and driving simulators can be used for poststroke patients (Recommendation IIa-B).

MEDICATION ADHERENCE

Medication adherence is defined as "the extent to which a person's behavior when using medications corresponds with the agreed recommendations from a health care provider".¹⁶⁴ Five dimensions and two factors influence adherence behavior. The five dimensions are the patient, the health system, socioeconomic status, therapy, and health status.

The factors are classified as intentional, such as skipping a dose of the drug when considering that the symptoms are under control, and unintentional, such as skipping a dose due to forgetfulness.¹⁶⁴

Limitations to the adherence to medications affect ~ 50% of poststroke individuals.¹⁶⁵ Patients with atrial fibrillation and greater adherence to oral anticoagulants have a lower risk of stroke, transient ischemic attack, and mortality.¹⁶⁵ Better adherence to statins and antihypertensives is also associated with a lower risk of stroke.¹⁶⁶ On the other hand, non-adherence is associated with a greater chance of recurrence, mortality, long-term disability, and dementia.¹⁶⁷

Better medication adherence is associated with better knowledge of medications and the need to use them.¹⁶⁸ Although promising, the use of automated telecommunication interventions, including text messages and interactive voice response, showed conflicting results in two meta-analyses^{168,169} that analyzed medication adherence for secondary prevention of cardiovascular disease. Intervention with telephone support, conducted mainly by nurses, can be effective.¹⁶⁹

Medication adherence improved after self-management interventions to better control risk factors in poststroke individuals.¹⁷⁰ Interventions based on cognitive and behavioral orientation, such as simplifying the act of taking medications, environment reminders, and information to improve drug treatment beliefs, improved medication adherence after stroke.¹⁷⁰

Recommendations

- Interventions based on cognitive and behavioral orientation should be conducted to improve medication adherence (Recommendation I-A);
- Self-management interventions to control risk factors may be beneficial to improve poststroke medication adherence (Recommendation IIa-A);
- Information about medications and their use is recommended to improve medication adherence after stroke. (Recommendation I-B)
- Telephone calls can be effective in improving medication adherence (Recommendation IIa-A);
- The benefits of telecommunication are uncertain (Recommendation IIb-A).

PALLIATIVE CARE

Neurological palliative care (PC) has become increasingly important and relevant in studies worldwide. Considering that it is comprehensive, multidisciplinary care, it makes perfect sense to apply it to patients with neurological diseases, especially those affected by stroke, to alleviate and prevent the suffering of people with serious, life-threatening diseases.¹⁷¹

Palliative care should be initiated early in stroke patients, not only when the patient is close to death.¹⁷² All patients who have suffered a stroke and have reduced quality of life and life expectancy, as well as their families, should have access to PC.¹⁷³ Ideally, PC should be provided by the

neurology or Intensive Care Unit (ICU) team and by a PC service at the time of diagnosis.¹⁷³

There are three possible models for the integration of neurological care and PC.¹⁷³ The first one is the consultative model, through an exceptional evaluation via consultation with the PC team. The second one is the integrated model, in which the teams work together simultaneously. The third one is primary neuropalliative care, in which the neurologist is trained to provide primary PC and determine when there is a need for referral to a specialized team.

In the last model, neurological PC provides greater involvement, as the neurologist who follows the patient since the diagnosis has a stronger connection and more data to predict and define a therapeutic plan.¹⁷³

The main contributions of the neurologist in primary PC, which can be useful for every professional involved in the care of the patient, are recognizing the PC needs associated with each neurological disease, identifying and treating pain, providing basic psychosocial and spiritual support, acquiring communication skills (including empathic listening), evaluating the prognosis, supporting patients and families regarding tragic choices, being aware of last-resort PC options, and acknowledging and managing the caregiver's distress and needs.¹⁷²

Neurologists should also know how to identify an indication for specialized (or secondary) PC, which includes management of refractory and complex physical symptoms, management of complex psychological and spiritual suffering, assistance in conflict resolution in relation to the objective and treatment options, transfer to hospice, and end-of-life management.¹⁷³

Recommendations

- Palliative care is recommended for people with stroke in cases of reduced quality of life and reduced life expectancy (Recommendation I-C);
- Palliative care should be provided by neurologists, the ICU team, and the PC Service at the time of diagnosis (Recommendation I-B);
- Formal assessment of PC should be recommended in end-of-life situations, in the presence of refractory pain, dyspnea, agitation, mood disorders, long-term feeding assistance, ventilation, palliative extubation, and assistance in resolving conflicts between family members and health teams (Recommendation I-B).

CEREBROVASCULAR EVENTS RELATED TO SARS-COV-2 INFECTION

Infection by severe acute respiratory syndrome coronavirus 2 (SARS-Cov-2) has been heavily associated with short- and medium-term neurological complications.¹⁷⁴ These conditions increase the risk of headache, encephalopathy, epileptic seizures, delirium, and cerebrovascular events such as ischemia, intracranial hemorrhage, central venous thrombosis, and subarachnoid hemorrhage.¹⁷⁴ The incidence of cerebrovascular disease in patients with active SARS-Cov-2 infection ranges from 2.3% to 6%, and it is higher among patients with

more severe infection.¹⁷⁴ One study¹⁷⁴ reported that central venous thrombosis occurred in 0.3% of cases, and infection increased the frequency of involvement of multiple cerebral arterial territories, with more extensive lesions and subsequent greater neurological severity. At the same time, younger people were more affected than controls.¹⁷⁴

The coronavirus disease 2019 (COVID-19) pandemic has radically changed processes, patient access, and stroke care. However, the nature and quality of stroke care across the entire service line have proven benefits in long-term results.¹⁷⁵ Standards and scope in the care of stroke patients must be maintained; otherwise, the recurrence rate of stroke and ongoing disabilities in general will increase and generate a new burden on an already overloaded service network. Overall, measures to preserve the best stroke management practices must be implemented in the context of the pandemic across the health system. Alternative care models such as telerehabilitation may provide greater access to care for stroke patients during the COVID-19 pandemic.¹⁷⁵ However, the literature is still scarce, and robust evidence on stroke rehabilitation related to SARS-CoV-2 infection is lacking.

Recommendations

- Rehabilitation strategies must comprise a multidisciplinary approach focusing on neurological impairments and disabilities after stroke that is related to SARS-CoV-2 infection (Recommendation IIb-C);
- Access to specialized centers such as stroke units, outpatient care, early support on discharge, and community stroke rehabilitation might be considered for stroke related to SARS-CoV-2 (Recommendation IIb-C).

FUTURE OF STROKE REHABILITATION

The flourishing of rehabilitation science has broadened knowledge about the heterogeneity of plasticity and recovery mechanisms in different individuals and poststroke phases.¹⁷⁶ To develop clinically-relevant strategies, solid bridges need to be built between studies in animals, proof-of-concept studies, randomized clinical trials in different phases, pragmatic studies, good-quality meta-analyses, and the practical needs of the patients, their families, professionals, and health services. In recent years, studies such as EXCITE, FLAME, FOCUS, and AVERT (for a review, please check the study by Cramer¹⁷⁷), among others, have shown that it is possible to test rehabilitation interventions and understand that patient characteristics are crucial for choosing therapies with a greater likelihood of success. "Precision rehabilitation" with realistic and individualized goals can thus be implemented.

With this approach, it becomes crucial to define "the right therapy for the right patient at the right time". Consensus on outcomes to be used in rehabilitation research, advances in neurophysiology techniques, structural and functional neuroimaging, genetics, data science, and artificial intelligence (AI), recognition of the importance of interdisciplinary work, patient opinions or preferences regarding the goals of the rehabilitation process, as well as the involvement of patients

in this process, have contributed to increasing innovations.^{178,179} Among the techniques that may be included in poststroke rehabilitation in the future, for example, through the enhancement of adaptive mechanisms of plasticity, are the use of drugs, non-invasive brain-computer interface (NIBCI), and behavioral interventions.¹⁸⁰

Social isolation during the COVID-19 pandemic underscored the need to develop telerehabilitation tools that use strategies such as videoconferencing to supervise rehabilitation activities. A study¹⁷⁹ compared this intervention with the same rehabilitation protocol applied in an out-of-home environment and observed an improvement in the levels of disability, balance, and stress of the caregiver without distinctions among groups. Telerehabilitation may be effective for motor rehabilitation and is less costly than conventional therapy.¹⁷⁸ Technological advances may increase the effectiveness of different telerehabilitation techniques and leverage other promising perspectives such as NIBCI,¹⁸⁰ wearable sensors,¹⁸¹ devices for communication in critically-ill patients,¹⁸² feedback and motivation systems,¹⁸³ and interactive robots,¹⁸⁴ among others. Despite many exciting possibilities, there is still a gap between research and the daily practice. For the design, testing, and implementation of useful strategies in the practice, it is essential that networks bring together researchers and rehabilitation professionals so that multicenter studies can be performed by considering the needs and opportunities in local, regional, or national cost-effectiveness contexts. Interventions that work in other countries may not work well in Brazil, and vice versa. Facilitators and barriers to rehabilitation can be very different in a large urban center and a small town in the heart of the Amazon. Access to rehabilitation after stroke in different Brazilian regions has been evaluated by the Access to Rehabilitation after Stroke (AREA) study.¹⁸⁵ Therapies based on new technologies do not always result in clinical benefits and are sometimes accompanied by costs that make them unaffordable for many. Therefore, it is crucial to choose evidence-based rehabilitation interventions suited for our reality. By doing so, we will be able to drastically impact the quality of life of millions of people with stroke.

SUGGESTED SITES FOR PATIENTS AND CAREGIVERS

- Ação AVC: <http://www.acaoavc.org.br>
- Associação Brasil AVC: <https://abavc.org.br>
- Orientações Multidisciplinares para Pacientes Pós AVC – UAVC HCFMB-UNESP: <https://drive.google.com/file/d/1UuoYNR7jcPkgbH5SK3hWLyopfYSKmK2W/view>
- Rede Brasil AVC: <http://www.redebrasilavc.org.br>
- American Stroke Association: <https://www.stroke.org/>
- Heart and Stroke Foundation-Canadian Partnership for Stroke Recovery: <http://www.canadianstroke.ca/>
- The Internet Stroke Center: <http://www.strokecenter.org>
- World Stroke Organization: <https://www.world-stroke.org>

CONCLUSIONS

The field of rehabilitation is open to incorporating new interventions to enhance the practice and the care after stroke. There have been significant breakthroughs in the last two decades through randomized controlled trials on stroke rehabilitation. High-level evidence supports the following recommendations: early speech, language, and swallowing therapy; specific training exercises for balance; botulinum toxin to reduce spasticity; mirror therapy; mental practice; unilateral and bilateral training; strengthening of upper limb improvement; cardiorespiratory and resistance training for gait recovery; physical activity as an adjunctive treatment to cognitive decline; and home planned rehabilitation after stroke. Future research is needed to establish the role of new technologies, such as neuromodulation, robotics, VR, and telerehabilitation as a routine in the clinical practice.

Supplementary material is available online.

Authors' Contributions

Introduction – CM, RZ: conceptualization, writing, review, editing, and validation of the original draft. Disorders of communication: aphasia, dysarthria, and apraxia of speech – LIZM, KZO: conceptualization, writing, review, editing, and validation of the original draft; MCL: participation as reviewer. Dysphagia – PWT: conceptualization, writing, review, editing, and validation of the original draft. Postural control and balance – LAPSS: conceptualization, writing, review, editing, and validation of the original draft; ROC: participation as reviewer. Ataxias – LAPSS: conceptualization, writing, review, editing, and validation of the original draft; ROC: participation as reviewer. Spasticity – CM: conceptualization, writing, review, editing, and validation of the original draft; MCL: participation as reviewer. Upper limb – CM, ABC, ROC: conceptualization, writing, review, editing, and validation of the original draft. Mobility – ROC, DMCC, RDMC, CM: conceptualization, writing, review, editing, and validation of the original draft. Cognition – FMMC, BSC, NAFF: conceptualization, writing, review, editing, and validation of the original draft; KJA: participation as reviewer. Unilateral spatial neglect – GJL: conceptualization, writing, review, editing, and validation of the original draft. Sensory impairment (hearing, vision, and touch) – ES, TPO, CM, MEPP: conceptualization, writing, review, editing, and validation of the original draft; KJA: participation as reviewer. Rehabilitation continuity: home rehabilitation, return to leisure, work, and driving – SSC, LAPSS, GJL: conceptualization, writing, review, editing, and validation of the original draft. Medication adherence – MHST, BCO, BGRBO: conceptualization, writing, review, editing and validation of the original draft. Palliative care – LON, LCG, CGL: conceptualization, writing, review, editing, and validation of the original draft. Cerebrovascular events related to SARS-CoV-2 infection – JBCA, GSS: conceptualization, writing, review, editing, and validation of the original

draft; RB: participation as reviewer. Future of stroke rehabilitation – ABC, GJL, ROC: conceptualization, writing, review, editing, and validation of the original draft. Suggested sites for patients and caregivers – LON: conceptualization, writing, review, editing, and validation of the original draft. Participation as reviewers of the entire paper: OMPN, JJFC, SCOM. CM: general coordinator; CM, RB, LON, MTP, SCSAM, ROC, GJL: coordinating group; RB: standardization and guideline coordinator; RB, CM, LON, MTP, SCSAM, ROC, GJL: standards and guidelines council; execution: Scientific Department of Neurological Rehabilitation of the Brazilian Academy of Neurology.

Conflict of Interest

The authors have no conflict of interests to declare.

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