

in order to evaluate the dose-effectiveness of the treatment. In addition, because of the typically bilateral involvement of UL in MS, future studies should explore the possibility to implement an alternating CIMT protocol in order to increase UL functionality of both arms.

We recommend the need for future studies to define standardized dose-effective CIMT protocols with a clearly defined number and length of sessions, frequency and percentage of constraint that could be feasible for both inpatient and outpatient settings.

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Conflicts of interest.—The authors certify that there is no conflict of interest with any financial organization regarding the material discussed in the manuscript.

Authors' contributions.—Claudio Solaro, Erica Grange, Giorgio Ferriero and

Luca Dileo have given substantial contributions to study conception and design, data acquisition, analysis and interpretation, Claudio Solaro and Erica Grange to manuscript writing, Ferriero Giorgio to manuscript critical revision. All authors read and approved the final version of the manuscript.

History.—Article first published online: January 5, 2022. - Manuscript accepted: January 3, 2022. - Manuscript revised: December 15, 2021. - Manuscript received: April 20, 2021.

Supplementary data.—For supplementary materials, please see the HTML version of this article at www.minervamedica.it

(Cite this article as: Grange E, Ferriero G, Dileo L, Solaro C. Constraint-induced movement therapy for upper limb rehabilitation in multiple sclerosis. *Eur J Phys Rehabil Med* 2022;58:497-8. DOI: 10.23736/S1973-9087.22.07025-3)

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European Journal of Physical and Rehabilitation Medicine 2022 June;58(3):498-501

DOI: 10.23736/S1973-9087.22.07593-1

Rehabilitation and COVID-19: update of the rapid living systematic review by Cochrane Rehabilitation Field as of February 28th, 2022

The present update follows the methodology defined in the 3rd edition of the rapid living systematic review (RLSR) conducted as part of the Cochrane Rehabilitation REH-COVER (Rehabilitation COVID-19 Evidence-based Response) Action.¹ Table I lists the main characteristics of this update.¹

We identified 7407 studies from the databases. After removing duplicates and title and abstract screening, we evaluated 105 studies of which we included 38 in the qualitative synthesis. Tables II²⁻⁴⁰ and III⁴¹ present the distribution of selected studies stratified by limitations of functioning of rehabilitation interest (LFRI), disease phase and rehabilitation setting (Table II), research question, and study design (Table III). Figures in Table II and III are displayed in face of the cumulative data from all papers included in the RLSR 3rd edition (and published from May 1st, 2021 through February 28th, 2022).

The main findings from the current bi-monthly update concern:

- the relevance of dysphagia in COVID-19 patients admitted to the intensive care units (ICUs). Two prospective cohort studies, totaling 55 cases, focused attention on two comparable cohorts of adults (mean age: 61¹⁷ vs. 65 years;¹⁶ males: 79%¹⁷ vs. 81.5%¹⁶)

TABLE I.—Main characteristics of this update.

Date of search	March 2 nd , 2022, looking for papers published from January 1 st up to February 28 th 2022
Methods	No changes to the 3 rd edition of the Rehabilitation and COVID-19 rapid living systematic review ¹
Consolidated online table of papers of all editions	https://bit.ly/rr--map
Table of the present update	https://bit.ly/2201-02
Interactive living evidence map	https://bit.ly/rr-dyn

TABLE II.—Distribution of studies by limitations of functioning of rehabilitation interest (LFRI),² disease phase, and rehabilitation setting.³⁻⁴⁰

Parameter	Classification	Current update (38 studies)			Total 3 rd edition (186 studies)	
		N.	%	Citation	N.	%
LFRI	Nervous system structures/functions	11	28.9%	3-13	31	16.7%
	Respiratory structures/functions	2	5.3%	14, 15	55	29.6%
	Digestive functions	2	5.3%	16, 17	3	1.6%
	Cardiovascular functions	0	0%		4	2.2%
	Any other body structure and function	13	34.2%	18-30	71	38.2%
	Any activity limitation and participation restriction	10	26.3%	31-40	22	11.8%
Disease phase	Acute COVID-19 infection	8	21.1%	15-17, 21-23, 26, 39	21	11.3%
	Ongoing symptomatic COVID-19	5	13.2%	4, 8, 13, 25, 40	41	22.0%
	Post COVID-19 condition	25	65.8%	3, 5-7, 9-12, 14, 18-20, 24, 27-38	121	65.1%
Rehabilitation setting	Impact of COVID-19 (any phase) on people with disability	0	0%		3	1.6%
	Rehabilitation in acute care	5	13.2%	15-17, 23, 39	10	5.4%
	Post-acute specialized	2	5.3%	30, 40	7	3.8%
	Post-acute general	6	15.8%	3, 4, 18, 25, 34, 36	14	7.5%
	Specialized outpatient	2	5.3%	12, 29	9	4.8%
	General outpatient	0	0%		2	1.1%
	Home-care	0	0%		13	7.0%
	Rehabilitation in social assistance	0	0%		1	0.5%
N/A *	23	60.5%	5-11, 13, 14, 19-22, 24, 26-28, 31-33, 35, 37, 38	130	69.9%	

N/A: not applicable.

*A high proportion of studies reported LFRI in COVID-19 survivors, without focusing on a rehabilitation program.

TABLE III.—Distribution of studies by research question and study design, according to the Agency for Healthcare Research and Quality.⁴¹

Research question	RCT	Cross-sectional	Cohort	Quasi-experimental studies and Before-after or time series	Total current update N. (%)	Total 3 rd edition N. (%)
Epidemiology: clinical presentation	0	0	0	0	0	0
Epidemiology: prevalence	0	17	0	0	17 (44.7%)	90 (48.4%)
Epidemiology: natural history, determining and modifying factors	0	0	15	0	15 (39.5%)	55 (29.6%)
Micro-level: individuals	0	2	0	4	6 (15.8%)	41 (22.0%)
Meso-level: health services	0	0	0	0	0	0
Macro-level: health systems	0	0	0	0	0	0
Total current update N. (%)	0	19 (50%)	15 (39.5%)	4 (10.5%)	38 (100%)	186 (100%)
Total 3 rd edition, N. (%)	17 (9.1%)	91 (48.9%)	64 (34.4%)	14 (7.5%)	186 (100%)	

developing dysphagia during the ICU stay and followed up at hospital discharge. Both studies point to a significant association between dysphagia severity and duration of intubation, duration of mechanical ventilation, and ICU length of stay. In addition, the presence of tracheostomy was associated with the severity of dysphagia, duration to initiation of oral feeding, and time to resolution of dysphagia.¹⁶

- risk factors for developing post COVID-19 condition in adults hospitalized for COVID-19. Three large cohort studies^{18, 27, 28} enrolled 2550 COVID-19 survivors followed up at 9-12 months after hospital discharge. Overall, 57% were male; the cohort's mean age varied from 56 years²⁷ to 60.2¹⁸ and 61.1.²⁸ There was a progressive decrease in the percentage of subjects complaining of at least one symptom over time, with figures varying from one cohort to

another. For example, at least one persisting symptom is reported by 20% of subjects at 9 months of hospital discharge in one study,²⁷ by 92% of subjects at 12 months, in another,¹⁸ whereas ≥ 3 symptoms are reported by 25.3% subjects at 12 months, in the third one.²⁸ Two studies^{18, 27} draw attention to the adverse role of the female sex and a slower or incomplete recovery in the acute phase, eventually resulting in a post-COVID-19 condition. According to Fernandez *et al.*,³⁸ symptom persistence in COVID-19 survivors was associated with limitations in leisure/social, instrumental, and basic activities, observed in 21%, 18%, and 14% of subjects at 12 months, respectively;

- features of post-COVID-19 condition in pediatric patients. In a cross-sectional study of 16,836 COVID-19 patients aged 0 to 17 years, 0.8% cases reported symptoms lasting >4 weeks, compared

to a control group of 16642 SARS-CoV-2 negative children.¹⁹ The most common symptoms were fatigue, loss of smell and loss of taste, dizziness, muscle weakness, chest pain, and respiratory problems, whereas concentration difficulties, headache, muscle- and joint pain were also reported by controls. In most cases, the post COVID-19 condition resolved within 1-5 months;

- efficacy of a rehabilitation program in adults with post COVID-19 condition. Two pre-post studies^{29, 30} used aerobic and resistance training with 3 sessions/week for either six³⁰ or eight weeks²⁹ in adults with post COVID-19 condition. Samples were of 50 cases (age: 55.8±9.7 years, 70% males)³⁰ and 58 cases (mean age 46.8±12.6; 57% males),²⁹ respectively. Both studies observed improved lung function after treatment; Nopp *et al.*³⁰ also reported symptom severity decrease and endurance increase.

Overall, the findings collected in this update contribute to the hypothesis that people hospitalized for COVID-19 are at risk of developing post COVID-19 conditions, with symptoms persisting beyond 12 months in more than 20% of cases. Patients with advanced age, ICU stay, and multiple symptoms at onset are more likely to suffer from long-term symptoms, negatively impacting physical and mental well-being. Pre-post studies suggest that 6-8 weeks of resistance and strength outpatient training might effectively relieve respiratory symptoms and increase endurance in adults with a post-COVID condition.

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Conflicts of interest.—The authors certify that there is no conflict of interest with any financial organization regarding the material discussed in the manuscript.

Authors' contributions.—Alessandro de Sire and Elisa Andrenelli equally contributed to this work as first authors. Database searching: Stefano G. Lazzarini. Study selection: Alessandro de Sire, Elisa Andrenelli, Francesco Negrini, Stefano G. Lazzarini, and Claudio Cordani. Data extraction: Alessandro de Sire, Elisa Andrenelli, and Francesco Negrini. Data analysis and interpretation: Alessandro de Sire, Elisa Andrenelli, Francesco Negrini, and Maria Gabriella Ceravolo. Manuscript drafting: Alessandro de Sire and Elisa Andrenelli. Study supervision: Maria Gabriella Ceravolo. Critical revision: Alessandro de Sire, Elisa Andrenelli, Francesco Negrini, Maria Gabriella Ceravolo, and the International Multiprofessional Steering Committee of Cochrane Rehabilitation REH-COVER action. Study submission: Francesco Negrini. All authors read and approved the final version of the manuscript.

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History.—Article first published online: May 25, 2022. - Manuscript accepted: May 18, 2022. - Manuscript received: May 16, 2022.

(Cite this article as: de Sire A, Andrenelli E, Negrini F, Lazzarini SG, Cordani C, Ceravolo MG; The International Multiprofessional Steering Committee of Cochrane Rehabilitation REH-COVER Action. Rehabilitation and COVID-19: update of the rapid living systematic review by Cochrane Rehabilitation Field as of February 28th, 2022. *Eur J Phys Rehabil Med* 2022;58:498-501. DOI: 10.23736/S1973-9087.22.07593-1)