Author(s):
Date: 2014-03-31
Question: Should Træning i ADL-aktiviteter vs Standardbehandling, ingen behandling eller placebo be used in Voksne personer (alder 18+) med erhvervet hjerneskade?
Settings:
Bibliography:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Træning i ADL-aktiviteter	Standardbehandling, ingen behandling eller placebo	Relative (95% CI)	Absolute		
Aktivitet og deltagelse (PADL) ved afslutning af intervention (measured with: Barthel Index eller FIM-motor total; Better indicated by lower values)												
4[1]	randomised trials	serious[2,3,4,5]	no serious inconsistency	no serious indirectness	no serious imprecision	none	174	164	-	SMD 0.52 higher (0.26 to 0.78 higher)	⊕⊕⊕O MODERATE	CRITICAL
Rivermead Mobility Index (PADL) ved (Better indicated by higher values)												
1[6]	randomised trials	serious[2,4]	no serious inconsistency	no serious indirectness	no serious imprecision	none	63	55	-	MD 1.7 higher (0.4 to 3 higher)	⊕⊕⊕O MODERATE	CRITICAL
Aktivitet og deltagelse (PADL) ved sidste follow-up (6 eller 12 mÃ¥neder) (measured with: Barthel Index; Better indicated by higher values)												
7[7]	randomised trials	serious[2,3,4,5]	no serious inconsistency	no serious indirectness	serious[8]	none	549	503	-	SMD 0.61 higher (0.01 to 1.21 higher)	⊕⊕OO LOW	CRITICAL
Rivermead Mobility Index Follow-up (6 mÃ¥neder) (Better indicated by higher values)												
1[6]	randomised trials	serious[2,4]	no serious inconsistency	no serious indirectness	very serious[9,10]	none	63	55	-	MD 1.1 higher (0.2 lower to 2.4 higher)	⊕OOO VERY LOW	CRITICAL
Aktivitet og deltagelse (IADL) ved afslutning af intervention (measured with: COPM-perfromance sore ; Better indicated by higher values)												
1[11]	randomised trials	very serious[2,5,12]	no serious inconsistency	no serious indirectness	serious[10]	none	6	8	-	SMD 0.09 higher (0.96 lower to 1.15 higher)	⊕OOO VERY LOW	CRITICAL
Aktivitet og deltagelse (IADL) ved afslutning af intervention (measured with: COPM-satsifaction sore ; Better indicated by higher values)												
1[11]	randomised trials	very serious[2,5,12]	no serious inconsistency	no serious indirectness	serious[8]	none	6	8	-	SMD 1.26 higher (0.07 to 2.45 higher)	⊕OOO VERY LOW	CRITICAL
Aktivitet og deltagelse (IADL) ved afslutning af intervention (measured with: NEADL; Better indicated by higher values)												
1[13]	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	serious[10]	none	86	82	-	MD 4.54 higher (0.74 lower to 9.84 higher)	⊕⊕OO LOW	CRITICAL
Aktivitet og deltagelse (IADL) ved sidste follow-up (6 eller 12 mÃ¥neder) (measured with: NEADL; Better indicated by higher values)												
6[14]	randomised trials	serious[2,3,4,5]	no serious inconsistency	no serious indirectness	serious[8]	none	494	353	-	SMD 0.21 higher (0.03 to 39 higher)	⊕⊕OO LOW	CRITICAL
Aktivitet og deltagelse (IADL) ved sidste follow-up (10 mÃ¥neder) (measured with: NEADL; Better indicated by higher values)												
1[13]	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	serious[10]	none	86	82	-	MD 3.94 higher (1.52 lower to 10.3 higher)	⊕⊕OO LOW	CRITICAL
Deltagelse ved afslutning af intervention (measured with: RNLI; Better indicated by higher values)												
1[11]	randomised trials	very serious[2,5,12]	no serious inconsistency	no serious indirectness	very serious[10]	none	6	8	-	MD 0.15 lower (1.22 lower to 0.91 higher)	⊕OOO VERY LOW	CRITICAL
Livskavlitet ved afslutning af intervention (measured with: SF-36 Fysisk funktion; Better indicated by higher values)												
1[11]	randomised trials	very serious[2,5,12]	no serious inconsistency	no serious indirectness	very serious[10]	none	6	8	-	SMD 0.2 lower (1.27 lower to 0.86 higher)	⊕OOO VERY LOW	CRITICAL
Livskvalitet ved afslutning af intervention (measured with: SF-36 Mental funktion; Better indicated by higher values)												
1[11]	randomised trials	very serious[2,12]	no serious inconsistency	no serious indirectness	very serious[10]	none	6	8	-	SMD 0.07 lower (1.13 lower to 0.99 higher)	⊕OOO VERY LOW	CRITICAL

Poor outcome (assessed with: Død ved sidste follow-up (6 eller 12 måneder))												
8[15]	randomised trials	serious[2,3,4]	no serious inconsistency	no serious indirectness	serious[16]	none	66/668 (9.9%)	63/528 (11.9%)	RR 0.83 (0.57 to 1.18)	20 fewer per 1000 (from 51 fewer to 21 more)	⊕⊕OO LOW	CRITICAL
Poor outcome (assessed with: Død eller fald i funktionsniveau eller afhængig af hjælp)												
7[17]	randomised trials	serious[2,3,4,5]	no serious inconsistency	no serious indirectness	no serious imprecision	none	225/607 (37.1%)	209/458 (45.6%)	RR 0.77 (0.62 to 0.93)	105 fewer per 1000 (from 32 fewer to 173 fewer)	⊕⊕⊕O MODERATE	CRITICAL

[1] Estimat baseret på NICE guideline REFID 3 (Chiu 2004; Sackley 2006)); systematisk review (Cochrane) af West et al, 2008; REFID 1639 (Donkervoort 2001); systematisk review (Cochrane) af Bowen et al, 2011; REFID 1828 (Edmanns 2000))

[2] Patienter og behandler ikke blindet

[3] Uklar ramdomisering i enkelte af de inkluderede studier

[4] Uklar allokering i studiet elle i enkelte af de inkluderede studier i metaanalysen

[5] Uklar blinding ved outcome undersøgelse i studiet eller i enkelte af de inkluderede studier i metaanalysen

[6] NICE guideline; REFID 3 (Sackley 2006)

[7] Estimat baseret på 7 studier (estimat fra systematisk review (Cochrane) af Legg et al, 2006; REFID 4511 (Corr, 1995; Logan 1997; Walker 1999; Gilbertson 2000; Parker 2001)); (estimat fra NICE guideline REFID 3 (Sakley 2006)); (estimat fra systematisk review (Cochrane) af West et al, 2008; REFID 1639 (Donkervoort, 2001))

[8] Konfidensinterval er bredt og indeholder effektstørrelser fra triviel til stor

[9] Konfirdensinterval krydser den præsoecificerede nedre grænse for Minimal Important Difference på -0.9 i NICE REFID 3

[10] Konfidensinterval er bredt og indeholder 0 (=ingen forskel mellem grupper)

[11] Egan 2007; REFID 5314.

[12] Frafald over 20% (Attrition)

[13] Logan 2004; REFID 6111

[14] Estimat baseret på systematisk review (Cochrane) af Legg et al, 2006; REFID 4511 (Corr, 1995; Drummond 1995; Logan 1997; Walker 1999; Gilbertson 2000; Parker 2001))

[15] Estimat baseret på systematisk review (Cochrane) af Legg et al, 2006; REFID 4511 (Corr, 1995; Drummond 1995; Logan 1997; Walker 1999; Gilbertson 2000; Parker 2001; Sackley 2003 (studie identisk med Sackly 2006 i NICE)); systematisk review (Cochrane) af West et al, 2008; REFID 1639 (Donkervoort, 2001)).

[16] Konfirdensinterval for samlede estimat af RR er bredt og indeholder 1 (=Ingen forskel i risiko)

[17] Estimat baseret på systematisk review (Cochrane) af Legg et al, 2006; REFID 4511 (Corr, 1995; Drummond 1995; Logan 1997; Walker 1999; Gilbertson 2000; Parker 2001; Sackley 2003 (Studie identisk med Sackley 2006 i NICE)).

Author(s):
Date: 2014-04-11
Question: Should Virtual reality vs usual care, placebo, no treatment be used in Brain Damage?
Settings:
Bibliography:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Virtual reality	Usual care, placebo, no treatment	Relative (95% CI)	Absolute		
Kognitive funktioner - not reported												
0	-	-	-	-	-	none	-	-	-	-		IMPORTANT
Tonus i overekstremitet - not reported												
0	-	-	-	-	-	none	-	-	-	-		CRITICAL
Håndfunktion (measured with: Grebsstyrke målt i kg ved afsluttet indsats; Better indicated by higher values)												
2[1]	randomised trials	serious[2,3]	no serious inconsistency	no serious indirectness	serious[4]	none	23	21	-	MD 3.55 higher (0.2 lower to 7.3 higher)	⊕⊕OO LOW	CRITICAL
Armfunktion (measured with: Målt med Fugl Meyer for armfunktion ved afsluttet indsats; Better indicated by higher values)												
9[5]	randomised trials	serious[2,3,6,7]	no serious inconsistency	no serious indirectness	no serious imprecision	none	143	121	-	MD 4.30 higher (2.05 to 6.55 higher)	⊕⊕⊕O MODERATE	CRITICAL
Armfunktion (measured with: Målt med Fugl Meyer ved opfÃ¸lgning (3 måneder); Better indicated by higher values)												
1[8]	randomised trials	serious[2,3,6,7]	no serious inconsistency	no serious indirectness	serious[4]	none	8	8	-	MD 7.10 higher (11.42 lower to 25.62 higher)	⊕⊕OO LOW	CRITICAL
Håndfunktion (measured with: Koordination målt med Box and Block ved afsluttet indsats; Better indicated by higher values)												
1[9]	randomised trials	serious[2,3]	no serious inconsistency	no serious indirectness	serious[4]	none	18	17	-	MD 4.38 higher (4.28 lower to 13.04 higher)	⊕⊕OO LOW	CRITICAL
Armfunktion (aktivitetsniveau) (measured with: Målt med Action Research Arm test, Abbreviated Wolf Motor Function Test eller Chedoke ved afslutning af indsats; Better indicated by higher values)												
2[10]	randomised trials	serious[2,3]	no serious inconsistency	no serious indirectness	serious[4]	none	18	16	-	SMD 0.62 higher (0.33 lower to 1.57 higher)	⊕⊕OO LOW	CRITICAL
PADL (measured with: Målt med Barthel Index score eller Functional Independence Measure ved afslutning af indsats; Better indicated by higher values)												
6[11]	randomised trials	serious[2,3,6,7]	no serious inconsistency	no serious indirectness	no serious imprecision	none	90	69	-	SMD 0.67 higher (0.29 to 1.05 higher)	⊕⊕⊕O MODERATE	CRITICAL
PADL (measured with: Barthel Index ved opfølgning (3 måneder); Better indicated by higher values)												
1[12]	randomised trials	very serious[2,3,6]	no serious inconsistency	no serious indirectness	serious[4]	none	8	8	-	MD 3.4 higher (3.18 lower to 9.98 higher)	⊕OOO VERY LOW	CRITICAL
Skadevirkninger (assessed with: Fald, svimmelhed, hovedpine)												
2[13]	randomised trials	serious[2,3,6,7]	no serious inconsistency	no serious indirectness	serious[4]	none	2/16 (12.5%)	0/16 (0%)	OR 6.33 (0.26 to 152.86)	-	⊕⊕OO LOW	CRITICAL
Skadevirkninger - not measured												
0	-	-	-	-	-	none	-	-	-	-		CRITICAL
Deltagelse - not reported												
0	-	-	-	-	-	none	-	-	-	-		CRITICAL
Livskvalitet - not reported												
0	-	-	-	-	-	none	-	-	-	-		CRITICAL

[1] Estimat baseret på Systematisk review (Cochrane) af Lawer et al, 2011; REFID 3172 (Hausman 2008; Saposnik 2010)).

[2] Uklar allokering i studiet eller i enkelte af de inkluderede studier

[3] Patienter og behandler ikke blindet

[4] Konfidensinterval for enkeltestimater er brede og indeholder 0 (=ingen forskel mellem grupper)

[5] Estimat baseret på Systematisk review (Cochrane) af Lawer et al, 2011; REFID 3172 (Hausman 2009; Piron 2007, Piron 2009, Piron 2010, Sucar 2009)); (da Silva Cameirao 2011; REFID 6534); (Kwon 2012; REFID 6727); (Shin 2014; REFID 6659); Sin 2013; REFID 6446).
[6] Uklar ramdomisering i studiet eller i enkelte af de inkluderede studier (Selection bias)
[7] Uklar blinding ved outcome undersøgelse i studiet eller i enkelte af de inkluderede studier i metaanalysen (Detection bias)
[8] Etsimat baseret på da Silva Cameirao 2011; REFID 6534.
[9] Etsimat baseret på Sin 2013; REFID 6446.
[10] Estimati baseret på Systematisk review (Cochrane) af Lawer et al, 2011; REFID 3172 (Crosbie 2008; Saposnik 2010).
[11] Estimat baseret på Systematisk review (Cochrane) af Lawer et al, 2011; REFID 3172; (Kang 2009; Piron 2007; Piron 2010)); (da Silva Cameirao 2011; REFID 6534); (Kwon 2012; REFID 6727); (Shin 2014; REFID 6659).
[12] Estimat baseret på 1 studie (estimat fra da Silva Cameirao 2011; REFID 6534).
[13] Estimat baseret på 4 studier (estimat fra systematisk review (Cochrane) af Lawer et al, 2011; REFID 3172 (Crosbie 2008). (estimat fra Shin 2014; REFID 6659);

Author(s):
Date: 2014-04-11
Question: Should Virtual reality vs usual care, placebo, no treatment be used in Brain Damage?
Settings:
Bibliography:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Virtual reality	Usual care, placebo, no treatment	Relative (95% CI)	Absolute		
Kognitive funktioner - not reported												
0	-	-	-	-	-	none	-	-	-	-		IMPORTANT
Tonus i underekstremitet - not reported												
0	-	-	-	-	-	none	-	-	-	-		CRITICAL
Motorisk funktion underekstremitet - not reported												
0	-	-	-	-	-	none	-	-	-	-		
Balance (aktivitetsniveau) (measured with: Bergs Balance skala ved afslutning af indsats; Better indicated by higher values)												
7[1]	randomised trials	serious[2,3,4,5]	no serious inconsistency	no serious indirectness	no serious imprecision	none	63	61	-	MD 1.75 higher (0.17 to 3.33 higher)	⊕⊕⊕O MODERATE	IMPORTANT
Balance (assessed with: Ved opfølgning)												
0	No evidence available					none	-	-	-	-		
								0%		-		
Ganghastighed (measured with: Målt med meter per sekund ved afslutning af indsats; Better indicated by higher values)												
6[6]	randomised trials	serious[2,3,4,5]	no serious inconsistency	no serious indirectness	no serious imprecision	none	62	57	-	MD 0.09 higher (0.02 lower to 0.21 higher)	⊕⊕⊕O MODERATE	CRITICAL
Ganghastighed (measured with: Målt med Timed Up & Go ved afslutning af indsats; Better indicated by lower values)												
4[7]	randomised trials	serious[3,4,5]	no serious inconsistency	no serious indirectness	serious[8]	none	37	36	-	MD 0.41 higher (2.01 lower to 8.83 higher)	⊕⊕OO LOW	CRITICAL
Ganghastighed (measured with: Målt med 10 meter gangtest ved afslutning af indsats; Better indicated by lower values)												
2[9]	randomised trials	serious[2,4,5]	no serious inconsistency	no serious indirectness	serious[8]	none	17	16	-	MD 6.11 lower (17.19 lower to 4.97 higher)	⊕⊕OO LOW	IMPORTANT
Ganghastighed (assessed with: Ved opfølgning)												
0	No evidence available					none	-	-	-	-		
								0%		-		
PADL (assessed with: Ved opfølgning)												
0	No evidence available					none	-	-	-	-		
								0%		-		
Deltagelse - not reported												
0	-	-	-	-	-	none	-	-	-	-		CRITICAL
Livskvalitet - not reported												
0	-	-	-	-	-	none	-	-	-	-		CRITICAL
Skadevirkninger (assessed with: Fald, svimmelhed, hovedpine)												
2[10]	randomised trials	serious[2,3,4,5]	no serious inconsistency	no serious indirectness	no serious imprecision	none	0/19 (0%)	0/19 (0%)	Not estimable	-	⊕⊕⊕O MODERATE	CRITICAL
Skadevirkninger - not measured												
0	-	-	-	-	-	none	-	-	-	-		CRITICAL

[1] Estimat baseret på (Kim 2009 REFID 8332); (Barcala 2013 REFID 6252); (Cho 2012 REFID 6489); (Cho 2013 REFID 6459); (Cuthbert 2014 REFID 6422);(Fritz 2013 REFID 6453); (Gil-Gomez 2011 REFID 6647).
[2] Uklar ramdomisering i studiet eller i enkelte af de inkluderede studier
[3] Uklar allokering i studiet eller i enkelte af de inkluderede studier
[4] Patienter og behandler ikke blindet
[5] Uklar blinding ved outcome undersøgelse i studiet eller i enkelte af de inkluderede studier
[6] Estmat baseret på systematisk review (Cochrane) af Lawer et al, 2011; REFID 3172 (Jaffe 2004; Mirelman 2008;Yang 2008); (Fritz 2013 REFID 6453); (Gil-Gomez 2011 REFID 6647); (Park 2013 REFID 6428).
[7] Estimat baseret på (Barcala 2013 REFID 6252); (Cho 2012 REFID 6489); (Cho 2013 REFID 6459); (Gil-Gomez 2011 REFID 6647).
[8] Konfidensinterval for enkeltestimater er brede og indeholder 0 (=ingen forskel mellem grupper)
[9] Estmat baseret på (Gil-Gomez 2011 REFID 6647); (Park 2013 REFID 6428).
[10] Estimat baseret på (Cuthbert 2914, REFID 6422); (Gil-Gomez 2011, REFID 6674)

Author(s): MH
Date: 2014-01-23
Question: Should Functional Electrical Stimulation vs usual care, placebo or no intervention be used in adults with stroke?
Settings:
Bibliography:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Functional Electrical Stimulation	Usual care, placebo or no intervention	Relative (95% CI)	Absolute		
Gribestyrke (measured with: Grip strength (Newton) (post treatment effect); Better indicated by higher values)												
2[1,2]	randomised trials	very serious[3]	no serious inconsistency	no serious indirectness	no serious imprecision	none	21	20	-	MD 5.34 higher (9.63 lower to 20.31 higher)	⊕⊕OO LOW	
Fingerstyrke (measured with: Strength of finger extension (Newtons) (post intervention); Better indicated by higher values)												
2[4]	randomised trials	serious[5]	no serious inconsistency	no serious indirectness	no serious imprecision	none	76	-	-	MD 4.00 higher (1.7 lower to 9.7 higher)	⊕⊕⊕O MODERATE	
Ledbevægelighed albue (measured with: Range of motion (elbow extension (degrees)) (post treatment effect); Better indicated by higher values)												
1[6]	randomised trials	serious[7]	no serious inconsistency	no serious indirectness	serious[8]	none	9	9	-	MD 53.8 higher (22.92 to 84.68 higher)	⊕⊕OO LOW	
Ledbevægelighed hÃ¥ndled (measured with: Range of motion (wrist extension (degrees)) (post treatment effect); Better indicated by higher values)												
4[2,6,9]	randomised trials	serious[5]	no serious inconsistency	no serious indirectness	no serious imprecision	none	51	50	-	MD 2.16 higher (1.28 lower to 5.59 higher)	⊕⊕⊕O MODERATE	
Ledbevægelighed skulder (measured with: Range of motion (shoulder flexion (degrees)) (post treatment effect); Better indicated by higher values)												
1[6]	randomised trials	serious[7]	no serious inconsistency	no serious indirectness	serious[8]	none	9	9	-	MD 25.3 higher (10.07 lower to 60.67 higher)	⊕⊕OO LOW	
Ledbevægelighed MCP (measured with: Range of motion (MCP extension (degrees)) (post treatment effect); Better indicated by higher values)												
1[2]	randomised trials	very serious[3]	no serious inconsistency	no serious indirectness	no serious imprecision	none	9	9	-	MD 3.77 lower (14.74 lower to 7.2 higher)	⊕⊕OO LOW	
Fugl-Meyer (measured with: Fugl-Meyer Assessment - Modified (Post treatment effect); Better indicated by higher values)												
6[2,10]	randomised trials	very serious[3]	no serious inconsistency	no serious indirectness	no serious imprecision	none	78	78	-	MD 6.26 higher (3.87 to 8.66 higher)	⊕⊕OO LOW	
Fugl-Meyer (follow-up 6 months; measured with: Fugl-Meyer Assessment - Upper limb; Better indicated by higher values)												
1[11]	randomised trials	serious[5]	no serious inconsistency	no serious indirectness	no serious imprecision	none	23	23	-	MD 9.50 higher (3.59 to 15.41 higher)	⊕⊕⊕O MODERATE	
ARAT (follow-up 4 weeks; measured with: Change in Action Reach Arm test (low & high dose FES); Better indicated by higher values)												
1[12]	randomised trials	serious[5]	no serious inconsistency	no serious indirectness	no serious imprecision	none	44	22	-	MD 5.05 higher (0.08 to 10.03 higher)	⊕⊕⊕O MODERATE	
ARAT (follow-up 24 weeks; measured with: Change in Action Reach Arm test; Better indicated by higher values)												
2[12]	randomised trials	serious[3,13]	no serious inconsistency	no serious indirectness	serious	none[8]	11	11	-	MD 9.70 higher (2.35 to 17.05 higher)	⊕⊕OO LOW	
Box and Blocks (measured with: Box and Blocks (post intervention); Better indicated by higher values)												
3[14]	randomised trials	serious[3]	no serious inconsistency	no serious indirectness	serious[8]	none	28	29	-	MD 6.61 higher (0.53 to 12.68 higher)[15]	⊕⊕OO LOW	
FIM (measured with: Functional Indepence Measure (FIM) (post intervention); Better indicated by higher values)												
4[2,16]	randomised trials	serious[3]	no serious inconsistency	no serious indirectness	serious[8]	none	56	55	-	MD 2.06 higher (1.04 lower to 5.16 higher)	⊕⊕OO LOW	
FIM (follow-up 12 weeks; measured with: Functional Indepence Measure (FIM); Better indicated by higher values)												

1[17]	randomised trials	serious[5]	no serious inconsistency	no serious indirectness	no serious imprecision	none	14	14	-	MD 0.30 higher (4.94 lower to 4.34 higher)	⊕⊕⊕O MODERATE	
Modified barthel (follow-up 1 months; measured with: Modified Barthel Index; Better indicated by higher values)												
1[11]	randomised trials	serious[5]	no serious inconsistency	no serious indirectness	no serious imprecision	none	23	23	-	MD 8.8 higher (1.51 to 16.09 higher)	⊕⊕⊕O MODERATE	
Modified barthel (follow-up 6 months; measured with: Modified Barthel Index; Better indicated by higher values)												
1[11]	randomised trials	serious[5]	no serious inconsistency	no serious indirectness	no serious imprecision	none	23	23	-	MD 13.10 higher (7.38 to 18.82 higher)	⊕⊕⊕O MODERATE	
Modified Ashworth (measured with: The Modified Ashworth Scale of shoulder, elbow and wrist (post treatment); Better indicated by lower values)												
3[1,2,6]	randomised trials	very serious[5]	no serious inconsistency	no serious indirectness	no serious imprecision	none	30	29	-	MD 0.30 lower (0.75 lower to 0.15 higher)	⊕⊕OO LOW	
Modified Ashworth (follow-up 26 weeks; measured with: The Modified Ashworth Scale; Better indicated by lower values)												
2[18]	randomised trials	serious[5]	no serious inconsistency	no serious indirectness	no serious imprecision	none	37	37	-	MD 0.32 lower (0.62 to 0.02 lower)	⊕⊕⊕O MODERATE	

[1] Estimat fra NICE guideline (Chan 2009)
[2] Boyaci 2013
[3] Unclear blinding, randomisation and allocation concealment
[4] Estimater fra NICE (Powell 1999, Kimberley 2004)
[5] Unclear randomisation and allocation concealment
[6] Shomodozono 2014
[7] Inadequate blinding of participants
[8] Lack of precision
[9] Estimater fra NICE Guideline (Chan 2009; Sahin 2012)
[10] Estimater fra NICE (Alon 2007, Alon 2008, Chae 1998, Chan 2009, Lin 2011)
[11] Estimat fra NICE (Lin 2011)
[12] Estimat fra NICE (Hsu 2010, Mann 2005)
[13] Heterogenity I2=61.5%
[14] Estimat fra NICE (Alon 2007, Alon 2008, Kimberley 2004)
[15] Pooled estimat fra random effects meta-analyse
[16] Estimater fra NICE (Chae 1998, Chan 2009, Sahin 2012)
[17] Estimat fra NICE (Chae 1998)
[18] Estimater fra Nice (Popovic 2003, Lin 2011)

Author(s):
Date: 2014-04-29
Question: Should Functional Electrical Stimulation vs Usual care be used for Adults with ABI?
Settings:
Bibliography:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Functional Electrical Stimulation	Usual care	Relative (95% CI)	Absolute		
Fugl-Meyer UE (measured with: (end of intervention); Better indicated by lower values)												
1[1]	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	no serious imprecision	none	99	98	-	MD 0.24 lower (1.14 lower to 0.66 higher)	⊕⊕OO LOW	
Mobilitet (6 minute walk) (measured with: 6 minute walk (end of intervention); Better indicated by higher values)												
6[1,3]	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	no serious imprecision	none	372	-	-	SMD 0.22 higher (0.01 to 0.42 higher)	⊕⊕OO LOW	
Mobilitet (maximal gait speed) (measured with: 10 m gangtest (end of intervention); Better indicated by higher values)												
1[1]	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	no serious imprecision	none	99	98	-	MD 0.01 higher (0.03 lower to 0.05 higher)	⊕⊕OO LOW	
TuG (measured with: TuG (end of intervention); Better indicated by lower values)												
1[1]	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	no serious imprecision	none	99	98	-	MD 2.51 lower (5.84 lower to 0.82 higher)	⊕⊕OO LOW	
Rivermead (measured with: (end of intervention); Better indicated by lower values)												
1[4]	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	no serious imprecision	none	36	21	-	MD 1.3 higher (0.9 lower to 3.5 higher)	⊕⊕OO LOW	
Falls Incidence (assessed with: (end of intervention))												
1[1]	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	no serious imprecision	none	34/99 (34.3%)	43/98 (43.9%)	RR 0.78 (0.55 to 1.11)	439 fewer per 1000 (from 439 more to 439 more)	⊕⊕OO LOW	
								0%		-		

[1] Kluding 2013
[2] Unclear blinding, randomisation and allocation concealment
[3] Systematic review af Perira et al (2012)
[4] Everaert 2013

Author(s):
Date: 2014-01-29
Question: Should Resistance training (upper limb) vs usual care be used in adults with stroke?
Settings:
Bibliography:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Resistance training (upper limb)	Usual care	Relative (95% CI)	Absolute		
Armens og håndens bevægelser (measured with: Upper extemity Fugl-Meyer Assessment - Range of Movement changes (post treatment); Better indicated by higher values)												
1[1]	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	serious[3]	none	21	21	-	MD 0.15 lower (1.37 lower to 1.07 higher)	⊕⊕OO LOW	
Armens og håndens bevægelser (follow-up 9 months; measured with: Upper extemity Fugl-Meyer Assessment - Range of Movement changes; Better indicated by higher values)												
1[1]	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	serious[3]	none	21	21	-	MD 1.8 lower (3.43 to 0.17 lower)	⊕⊕OO LOW	
Armens og håndens bevægelser (measured with: Upper extemity Fugl-Meyer Assessment - motor function changes (post treatment); Better indicated by higher values)												
1[1]	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	serious[3]	none	21	21	-	MD 9.15 higher (2.35 to 15.95 higher)	⊕⊕OO LOW	
Armens og håndens bevægelser (follow-up 9 months; measured with: Upper extemity Fugl-Meyer Assessment - motor function changes; Better indicated by higher values)												
1[1]	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	serious[3]	none	21	21	-	MD 2.95 lower (10.19 lower to 4.29 higher)	⊕⊕OO LOW	
Mobilitet (measured with: Functional Independence Measure - mobility changes (FIM) - post treatment; Better indicated by higher values)												
1[1]	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	serious[4]	none	21	21	-	MD 0.90 higher (3.66 lower to 5.46 higher)	⊕⊕OO LOW	
Mobilitet (follow-up 9 months; measured with: Functional Independence Measure - mobility changes (FIM); Better indicated by higher values)												
1[1]	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	serious[4]	none	21	24	-	mean 3.23 lower (6.14 to 0.32 lower)	⊕⊕OO LOW	
Self-care (measured with: Functional Independence Measure - self-care changes (FIM) - post treatment; Better indicated by higher values)												
1[1]	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	serious[4]	none	21	21	-	MD 0.85 lower (4.26 lower to 2.56 higher)	⊕⊕OO LOW	
Self-care (follow-up 9 months; measured with: Functional Independence Measure - self-care changes (FIM); Better indicated by higher values)												
1[1]	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	serious[4]	none	21	21	-	MD 3.32 lower (6.48 to 0.16 lower)	⊕⊕OO LOW	
Skadevirkninger (Smerter) (measured with: Upper extemity Fugl-Meyer Assessment - Pain changes (post treatment); Better indicated by higher values)												
1[1]	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	serious[3]	none	21	21	-	MD 0.10 lower (1.38 lower to 1.18 higher)	⊕⊕OO LOW	
Skadevirkninger (Smerter) (follow-up 9 months; measured with: Upper extemity Fugl-Meyer Assessment - Pain changes; Better indicated by higher values)												
1[1]	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	serious[3]	none	21	21	-	MD 0.19 lower (2.63 lower to 2.25 higher)	⊕⊕OO LOW	

[1] Winstein 2004

[2] Unblinded study. Unclear randomization and inadequate allocation concealment. 27% lost to followâ€□up at 9 months

[3] Mean difference did not reach the agreed MID of 10% between the intervention and control groups.

[4] Mean difference did not reach the agreed MID of 17 points for the motor scale and the 3 points for the cognitive scale

Author(s): MH
Date: 2014-01-29
Question: Should Resistance training (lower limb) vs usual care be used in adults with stroke?
Settings:
Bibliography: NICE guideline

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Resistance training (lower limb)	Usual care	Relative (95% CI)	Absolute		
Neuromuskulær funktion (measured with: Muscle strength (end of intervention); Better indicated by higher values)												
2[1,2]	randomised trials	serious[3]	no serious inconsistency	no serious indirectness	serious[4]	none	24	26	-	SMD 0.75 higher (0.17 to 1.33 higher)	⊕⊕OO LOW	
Neuromuskulær funktion (measured with: Muscle strength knee extension - Nm (at follow-up); Better indicated by higher values)												
1	randomised trials	very serious[5]	no serious inconsistency	no serious indirectness	no serious imprecision	none	16	14	-	SMD 0.4 higher (0.3 lower to 1.13 higher)	⊕⊕OO LOW	
Mobilitet (measured with: Timed up and go (end of intervention); Better indicated by lower values)												
1[6]	randomised trials	serious[7]	no serious inconsistency	no serious indirectness	serious[8]	none	15	9	-	MD 1.2 lower (11.84 lower to 9.44 higher)	⊕⊕OO LOW	
Mobilitet (follow-up 5 months; measured with: Timed up and go; Better indicated by lower values)												
1[6]	randomised trials	serious[7]	no serious inconsistency	no serious indirectness	very serious[8]	none	15	9	-	MD 3.1 lower (16.67 lower to 10.47 higher)	⊕OOO VERY LOW	
Mobilitet (measured with: 6 minute walk test (m); Better indicated by higher values)												
1[9]	randomised trials	very serious[10]	no serious inconsistency	no serious indirectness	serious[11]	none	16	14	-	MD 13.9 lower (46.9 lower to 19.1 higher)	⊕OOO VERY LOW	
Mobilitet (follow-up 12 months; measured with: 6 minute walk test (m); Better indicated by higher values)												
1[9]	randomised trials	very serious[12]	no serious inconsistency	no serious indirectness	serious[13]	none	16	14	-	MD 4 higher (29 lower to 37 higher)	⊕OOO VERY LOW	
Mobilitet (measured with: Maximal gait speed (m/min) (end of intervention); Better indicated by higher values)												
2[6,9]	randomised trials	very serious[5,14]	no serious inconsistency	no serious indirectness	serious[15]	none	54	-	-	MD 1.2 higher (5.6 lower to 3.2 higher)	⊕OOO VERY LOW	
Mobilitet (measured with: Maximal gait speed (m/min) (end of follow-up); Better indicated by higher values)												
1[6]	randomised trials	serious[3]	no serious inconsistency	no serious indirectness	no serious imprecision	none	15	9	-	MD 20 lower (96 lower to 56 higher)	⊕⊕⊕O MODERATE	
Health related QoL (physical function) (measured with: SF36 - physical function (end of intervention); Better indicated by higher values)												
1[16]	randomised trials	serious[3]	no serious inconsistency	no serious indirectness	very serious[17]	none	10	10	-	MD 1.5 higher (4.2 lower to 7.2 higher)	⊕OOO VERY LOW	
Health related QoL (mental) (measured with: SF36 - mental health (end of intervention); Better indicated by higher values)												
1[16]	randomised trials	serious[3]	no serious inconsistency	no serious indirectness	very serious[17]	none	10	10	-	MD 2.8 higher (5 lower to 10.6 higher)	⊕OOO VERY LOW	

[1] From Cochrane review, Brazelli 2011 (Winstein 2004, Kim 2001)
[2] Kim 2001 (From Cochrane review, Brazelli 2011 used in NICE) and Severinsen 2013
[3] Unclear allocation concealment
[4] Confidence interval crosses one end of default MID (0.5) for single studies
[5] Unclear blinding and allocation concealment. Limitations were considered by study weights in meta-analysis
[6] Flansbjer 2008
[7] Allocation concealment not reported; No details of randomisation

[8] Mean difference did not reach the agreed MID of 10 sec between the intervention and control groups.
[9] Severinsen 2013
[10] Allocation concealment not reported; No details of randomisation
[11] Confidence interval crossed both ends of default MID
[12] Unclear randomisation; unclear allocation concealment
[13] Confidence interval crossed one end of the default MID
[14] Unclear allocation concealment. Limitations were considered by study weights in the meta-analysis
[15] Mean difference did not reach agreed MID of 0.16m/sec for the walking speed between the intervention and control group
[16] Kim 2001
[17] Confidence interval crossed both ends of MID (0.5)

Author(s): MH
Date: 2014-02-04
Question: Should konditionstræning vs usual care be used in adults with stroke?
Settings:
Bibliography: NICE Guideline

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Konditionstræning	Usual care	Relative (95% CI)	Absolute		
Kondition (measured with: peak VO2 (ml/kg/min)(end of intervention); Better indicated by higher values)												
20[1,2,3,4,5]	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[6]	none	932	-	-	SMD 1.19 higher (0.13 to 2.26 higher)[7]	⊕⊕⊕O MODERATE	
Kondition (measured with: peak VO2 (ml/kg/min)(end of follow-up); Better indicated by higher values)												
1[2]	randomised trials	serious[8]	no serious inconsistency	no serious indirectness	serious[6]	none	13	16	-	SMD 0.5 lower (1.3 lower to 0.2 higher)[7]	⊕⊕OO LOW	
Physical fitness (measured with: maximum cycling work rate (Watts)(end of intervention); Better indicated by higher values)												
4[9,10,11,12]	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[6]	none	107	114	-	MD 0.6 higher (0.18 to 1.02 higher)	⊕⊕⊕O MODERATE	
Physical fitness (measured with: maximum cycling work rate (Watts)(end of follow-up); Better indicated by higher values)												
1[9]	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[6]	none	40	44	-	MD 6.12 higher (24.06 lower to 36.3 higher)	⊕⊕⊕O MODERATE	
Mobility (measured with: maximal gait speed (end of intervention); Better indicated by higher values)												
20[3,4,13,14]	randomised trials	serious[15]	no serious inconsistency	no serious indirectness	no serious imprecision	none	814	-	-	SMD 7.37 higher (3.7 to 11.03 higher)	⊕⊕⊕O MODERATE	
Mobility (measured with: maximal gait speed (end of follow-up); Better indicated by higher values)												
5[13]	randomised trials	serious[8]	no serious inconsistency	no serious indirectness	serious[16]	none	174	138	-	MD 6.71 higher (2.4 to 11.02 higher)	⊕⊕OO LOW	
Mobility (measured with: 6 MW (end of intervention); Better indicated by higher values)												
19[2,3,4,13,14]	randomised trials	serious[8]	no serious inconsistency	no serious indirectness	serious[17]	none	1133	-	-	MD 25.95 higher (11.74 to 40.17 higher)	⊕⊕OO LOW	
Mobility (measured with: 6 MW (end of follow-up; Better indicated by higher values)												
5[2,3,13]	randomised trials	serious[15]	no serious inconsistency	no serious indirectness	no serious imprecision	none	148	114	-	MD 32.85 higher (8.37 lower to 74.07 higher)	⊕⊕⊕O MODERATE	
Physical function (measured with: TuG (end of intervention); Better indicated by lower values)												
3[18,19,20]	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[21]	none	64	67	-	MD 3.99 lower (6.91 lower to 1.08 higher)	⊕⊕⊕O MODERATE	
Disability (measured with: FIM (end of intervention); Better indicated by higher values)												
3[9,10,22]	randomised trials	serious[8]	no serious inconsistency	no serious indirectness	serious[23]	none	79	83	-	MD 0.21 higher (0.1 lower to 0.52 higher)	⊕⊕OO LOW	
Disability (measured with: Rivermead Mobility Index (end of intervention); Better indicated by higher values)												
5[3,13]	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[6]	none	250	243	-	MD 0.57 higher (0.03 lower to 1.17 higher)	⊕⊕⊕O MODERATE	
Disability (measured with: Rivermead Mobility Index (end of follow-up; Better indicated by higher values)												
2[3,13]	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[6]	none	72	78	-	MD 0.1 lower (1.2 lower to 1 higher)	⊕⊕⊕O MODERATE	
QoL physical functioning (measured with: SF-36 eller SF-12 (end of intervention); Better indicated by higher values)												
3[24,25,26]	randomised	serious[8]	serious[27]	no serious	serious[6]	none	33	31	-	SMD 0.82 higher (0.13	⊕OOO	

	trials			indirectness						lower to 1.77 higher)	VERY LOW	
QoL physical functioning (measured with: SF-36 (end of Follow-up); Better indicated by higher values)												
1[3]	randomised trials	serious[8]	no serious inconsistency	no serious indirectness	serious[28]	none	15	19	-	MD 4.8 higher (11.2 lower to 20.8 higher)	⊕⊕OO LOW	
QoL mental (measured with: SF-36 (end of intervention); Better indicated by higher values)												
2[3,13]	randomised trials	serious[8]	no serious inconsistency	no serious indirectness	serious[6]	none	70	-	-	MD 8.9 higher (4.4 to 13.5 higher)	⊕⊕OO LOW	
QoL mental (measured with: SF-36 (end of follow-up); Better indicated by higher values)												
1[3]	randomised trials	serious[8]	no serious inconsistency	no serious indirectness	serious[6]	none	15	19	-	MD 3.9 higher (7.84 lower to 15.64 higher)	⊕⊕OO LOW	
DÃ¸d (assessed with: End of intervention)												
22[13]	randomised trials	serious[8]	no serious inconsistency	no serious indirectness	no serious imprecision	none	0/541 (0%)	0%	-	-	⊕⊕⊕O MODERATE	
DÃ¸d (assessed with: End of follow-up)												
5[13]	randomised trials	serious[8]	no serious inconsistency	no serious indirectness	no serious imprecision	none	1/152 (0.66%)	1/152 (0.66%)	OR 1.00 (0.06 to 16.48)	0 fewer per 1000 (from 6 fewer to 92 more)	⊕⊕⊕O MODERATE	
								0%		-		

[1] + Systematic review of Pang et al {REFID 1296}
[2] Severinsen (2013) REFID 4346
[3] NICE 2013
[4] Systematic review Stoller et al
[5] Systematisk Review Marsden et al
[6] Confidence interval crosses default MID (0.5) for single studies or default 0.5*median control SD for 2 or more studies
[7] I2=95%
[8] Unclear allocation concealment and blinding (outcome assessor). Limitations were considered by study weights in the meta-analysis
[9] Bateman 2001
[10] Katz-Leurer 2003
[11] da Cunha 2002
[12] Potempa 1995
[13] Systematisk review (Cochrane) af Saunders et al REFID 1154
[14] Systematisk Review Hancock et al
[15] Unclear blinding (outcome assessor)
[16] Mean difference did not reach MID of 0.16 m/sec
[17] I2 = 52%
[18] Van De Port 2012
[19] Moore 2010
[20] Salbach 2004
[21] Lack of precision
[22] Cuveillo-Palmer 1988
[23] Mean difference did not reach the agreed MID of 17 points for the motor scale between the intervention and control group
[24] Globas 2012
[25] Aidar 2007
[26] Holmgren 2010
[27] Hetergogenity: I2=74%
[28] Confidence interval crosses both ends of default MID (0.5) for single studies or default 0.5*(median control SD) for 2 or more studies

Author(s):
Date: 2014-09-05
Question: Should Siddende balancetrÃ¦ning be used in erhvervet hjerneskade?
Settings:
Bibliography:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Siddende balancetrÃ¦ning	Control	Relative (95% CI)	Absolute		
Basal ADL (Better indicated by higher values)												
4	randomised trials	serious	no serious inconsistency	no serious indirectness	no serious imprecision	none	59	-	-	SMD 0.24 higher (0.78 lower to 0.3 higher)	⊕⊕⊕O MODERATE	

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Stående balancetræning uden biofeedback	Control	Relative (95% CI)	Absolute		
Balance (Better indicated by lower values)												
4	randomised trials	serious	no serious inconsistency	no serious indirectness	no serious imprecision	none	149	-	-	SMD 0.13 lower (0.44 lower to 0.19 higher)	⊕⊕⊕O MODERATE	
Rejse-sætte-sig (Better indicated by lower values)												
4	randomised trials	serious	no serious inconsistency	no serious indirectness	no serious imprecision	none	149	-	-	SMD 0.06 lower (0.26 lower to 0.38 higher)	⊕⊕⊕O MODERATE	
Gangfunktion (Better indicated by lower values)												
4	randomised trials	serious	no serious inconsistency	no serious indirectness	no serious imprecision	none	148	-	-	SMD 0.12 higher (0.2 lower to 0.44 higher)	⊕⊕⊕O MODERATE	

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Stående balancetræning med biofeedback	Control	Relative (95% CI)	Absolute		
Balance (Better indicated by lower values)												
12	randomised trials	serious	no serious inconsistency	no serious indirectness	no serious imprecision	none	186	-	-	SMD 0.21 lower (0.49 lower to 0.07 higher)	⊕⊕⊕O MODERATE	
Gangfunktion (Better indicated by lower values)												
12	randomised trials	serious	serious	no serious indirectness	no serious imprecision	none	251	-	-	SMD 0.01 lower (0.43 lower to 0.41 higher)	⊕⊕OO LOW	
Basal ADL-funktion (Better indicated by lower values)												
12	randomised trials	serious	no serious inconsistency	no serious indirectness	no serious imprecision	none	191	-	-	SMD 0.05 lower (0.33 lower to 0.23 higher)	⊕⊕⊕O MODERATE	

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Balancetræning under forskellige aktiviteter	Control	Relative (95% CI)	Absolute		
Balance (Better indicated by lower values)												
11	randomised trials	serious	serious	no serious indirectness	no serious imprecision	none	397	-	-	SMD 0.36 higher (0.07 to 0.64 higher)	⊕⊕OO LOW	
Gangfunktion (Better indicated by lower values)												
11	randomised trials	serious	no serious inconsistency	no serious indirectness	no serious imprecision	none	271	-	-	SMD 0.14 higher (0.1 to 0.37 higher)	⊕⊕⊕O MODERATE	
Basal ADL-funktion (Better indicated by lower values)												
11	randomised trials	serious	no serious inconsistency	no serious indirectness	no serious imprecision	none	211	-	-	SMD 0.38 higher (0.11 to 0.65 higher)	⊕⊕⊕O MODERATE	
Livskvalitet (Better indicated by lower values)												
11	randomised trials	serious	no serious inconsistency	no serious indirectness	no serious imprecision	none	252	-	-	SMD 0.15 lower (0.39 lower to 0.1 higher)	⊕⊕⊕O MODERATE	