Review of: "Comparing two identically protocolized, multicentre, randomized controlled trials on caregiver-mediated exercises poststroke: Any differences across countries?"

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This study[1] is aimed at much needed aspects of research implementation and adaptations in the field of stroke rehabilitation. With respect to the intervention implemented, the notable strengths of the study are the use of contemporary evidence based rehabilitation approaches (of including patient-caregiver dyads, home-based as well as in-person sessions, customized therapy sessions with periodic monitoring and progression, use of digital technology etc.). This has allowed meaningful findings to influence clinical decision making and modifications in processes.The use of an incremental 8-week program following TIDieR guidelines further strengthens the study reporting. The adequate intensity of therapy (30 mins, 5times/week) with follow-up going into the 3rd month seems to be sufficient especially with patients being encouraged to perform exercises during the weekend as well. Another interesting point is that of having an elaborate yet inclusive, inclusion criteria for the caregivers in the trial which probably allowed for better adherence, motivation to therapy protocols and reduced caregiver stress. In certain studies[2] where the inclusion of caregivers was not well-thought of study coordinators had to face the issue of retraining new caregivers of patients (as the previous ones refused to continue due to various reasons like health, time-commitment etc). The need to build capacity among formal and informal caregivers is one extended implication.[3]

Rehabilitation professionals across the world have and are continuing to develop evidence for effective treatment protocols and few have found success due to the various factors affecting rehabilitation outcomes. In such a scenario, raising the genuine question of socio-cultural and economic differences across countries that may affect rehabilitation practices is novel, especially while considering stark differences among high (HICs) and Low-and-Middle-Income-Countries (LMICs). Researchers have suggested that implementation studies exploring the use of established protocols in LMICs is the need of the hour instead of generating newer evidence within LMICs.[3] This implies the need for carefully designing studies when a global sample is being considered. Differences in health systems, processes, insurance coverage, public awareness on rehabilitation need, government policies on disability, community access to rehab centers, access to technology and remote supervision are additional factors that need to be considered apart from the ones mentioned in this study[1] especially in the LMIC context. Especially in countries like India, where the population is quite diverse, extra caution is required in generalizing results or designing and implementing rehab protocols.

Defining usual care is another important factor raised by this study. It is essential to understand the rehabilitation practices existing in different countries (and regional variations) before generalizing the results of rehab trials. Such usual care is further influenced by differences in health systems. In addition, interventions without coordination

from a dedicated multidisciplinary team currently do not have evidence of benefit.[2] It is also important to note that in LMICs, the absence of benefit of the family-rehabilitation
intervention has important implications for stroke recovery research, behavioral change, and task shifting in general, emphasizing the need for periodic monitoring by a trained health professional.
Lastly the suggestions listed in the study are the need of the hour in the field of stroke research and recovery. Although broader inclusion criteria are required, specifying the time post-stroke, severity of stroke and baseline functional capacities post-stroke is essential to improve generalizability.

References

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