



A. PEDro update (3 September 2018)

PEDro contains 41,192 records. In the 3 September 2018 update you will find:

- 32,397 reports of randomised controlled trials (31,574 of these trials have confirmed ratings of methodological quality using the PEDro scale)
- 8,136 reports of systematic reviews, and
- 659 reports of evidence-based clinical practice guidelines

For latest guidelines, reviews and trials in physiotherapy visit [Evidence in your inbox](#).

B. PEDro indexes 41,000+ reports



41000+

trials, reviews, guidelines

www.pedro.org.au



We are pleased to announce that PEDro has just achieved two new milestones for the amount of evidence. There are now 41,000+ reports of trials, reviews and guidelines indexed on PEDro.

C. Do you speak 简体中文, 한국어, Dansk, Norsk, Svenska, русский язык or فارسی?



PEDro needs more bilingual raters to help us evaluate trials. We are particularly looking for physiotherapists with an interest in research or evidence-based practice who speak 简体中文, 한국어, Dansk, Norsk, Svenska, русский язык or فارسی.

What is in it for you?

- Free PEDro rating training for the first five people who [contact us](#).
- Volunteer hours count towards continuous professional development.
- Knowing you are contributing to an evidence tool that supports the global physiotherapy community.

If you get involved, you can specify how much time you would like to contribute. It could be as simple as rating 2 articles each month!

If you are interested in finding out more, please [contact us](#).

D. Support for PEDro comes from the Motor Accident Insurance Commission and Axxon

We thank the [Motor Accident Insurance Commission](#) and [Axxon](#) who have just renewed their partnerships with PEDro for another year.

E. New guideline from the Royal Australian College of General Practitioners for the non-surgical management of hip and knee osteoarthritis: weight loss, walking, Tai Chi, cycling and Hatha yoga recommended

Best practice management of acute as well as long-term care for patients with osteoarthritis

includes optimal use of medicines, non-pharmacological management, appropriate care and referral pathways, patient self-management education and psychosocial support. Non-pharmacological interventions generally have low or no side effects and are used in conjunction with a pharmacological regimen to decrease pain and promote functioning and quality of life.

The guide makes the following recommendations for non-pharmacological therapy:

- Regular exercise is important for relieving pain and improving function in people with knee and/or hip osteoarthritis. For knee osteoarthritis, land-based exercise such as muscle strengthening, walking and Tai Chi are strongly recommended. Other land-based exercise that could be considered for some people include stationary cycling and Hatha yoga. The best land-based exercise for people with hip osteoarthritis could not be determined because of limited research. Aquatic exercise may be considered for some people with knee and/or hip osteoarthritis.
- Weight management is strongly recommended for people with knee and/or hip osteoarthritis who are overweight or obese. Cognitive behavioural therapy could be considered for some people, particularly in conjunction with exercise, and taking into account existing mental health conditions, personal preference, cost and access.
- Heat packs or hot water bottles may be applied as a self-management strategy.
- Using a cane or other devices (eg, walker, crutches) may be appropriate for some people with knee and/or hip osteoarthritis to help improve pain, mobility and balance.
- A short course of manual therapy or massage could be considered for some people with knee and/or hip osteoarthritis as an adjunct to lifestyle management.
- Transcutaneous electrical nerve stimulation that can be used at home may be appropriate for some people with knee and/or hip osteoarthritis.
- There is a conditional recommendation against the following treatments: therapeutic ultrasound, shockwave therapy, laser therapy, interferential therapy, footwear marketed for knee osteoarthritis, cold therapy, valgus braces and lateral wedge insoles for medial knee osteoarthritis, patellofemoral braces and Kinesio Taping.

Due to a lack of high-quality evidence, no recommendation can be made for the following: formal self-management programs, varus unloading braces and medial wedge insoles for lateral knee osteoarthritis, shock-absorbing insoles, arch supports, patellar taping and pulsed electromagnetic/shortwave therapy.

The Royal Australian College of General Practitioners. Guideline for the management of knee and hip osteoarthritis. 2nd edn. East Melbourne, Vic: RACGP, 2018.

[Read more on PEDro.](#)

F. Systematic review found that mirror therapy improves motor function after stroke

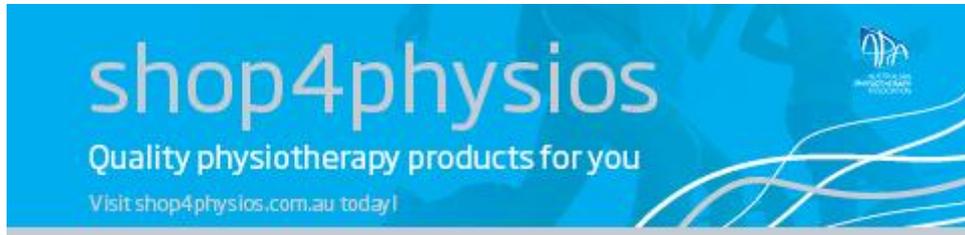
This recently updated Cochrane systematic review evaluates the effects of mirror therapy on motor function, pain and visuospatial neglect in people with stroke. Randomised controlled trials and crossover trials comparing mirror therapy with no treatment, sham therapy and other interventions were included. Interventions that used direct mirroring of movement in any format were included. Studies that combined mirror therapy with other interventions were included if at least 50% of the total intervention was mirror therapy. The primary outcome was motor function measured with any scale. Upper limb motor function was prioritised over lower limb motor function. Secondary outcomes were measures of motor impairment, pain and visuospatial neglect. A total of 62 studies (n=1982 participants) were included (57 randomised controlled trials, 5 crossover trials). Mirror therapy was provided three to seven times per week, for between 15 and 60 minutes in each session and for a duration of 2 to 8 weeks. Compared to other interventions, mirror therapy significantly improved motor function at the end of the treatment phase (standardised mean difference 0.47, 95% CI 0.27 to 0.67, 1173 participants from 36 trials, moderate quality evidence). However, these benefits of mirror therapy on motor function did not appear to persist 6 months after the end of treatment (standardised mean difference 1.20, 95% CI -0.78 to 3.18, 88 participants from 2 trials). Mirror therapy significantly improved motor impairment (standardised mean difference 0.49, 95% CI 0.32 to 0.66, 1291 participants from 39 trials, moderate quality evidence) and reduced pain (standardised mean difference -0.89, 95% CI -1.67 to -0.11, 248 participants from 6 trials, low quality evidence) at the end of the treatment phase when compared to other treatments. Mirror therapy was no better than other treatments for improving visuospatial neglect (standardised mean difference 1.06, 95% CI -0.10 to 2.23, 175 participants from 5 trials, low quality evidence). There was uncertainty around some effect estimates due to small samples in the included trials. Future trials with larger sample sizes are likely to increase the precision of the estimates reported in this review.

Thieme H et al. Mirror therapy for improving motor function after stroke. *Cochrane Database Syst Rev* 2018;Issue 7

[Read more on PEDro.](#)

G. Next PEDro update (October 2018)

The next PEDro update is on Monday 1 October 2018.



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Physiotherapy Evidence Database (PEDro)
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