

LETTER TO THE EDITOR

MISSED THERAPY TIME

Sir,

I read with interest the article by Slade et al. (1), which demonstrated a significant reduction in length of stay with an increased level of physiotherapy and occupational therapy within an in-patient neurorehabilitation setting.

I would like to highlight the important problem of missed therapy time (means of 7% and 5.2% in the experimental and control groups respectively). Missed therapy may be due to intrinsic and extrinsic factors, some of which are predictable and preventable. Clearly, where preventable, missed sessions can have therapeutic and economic consequences.

I wonder whether any of the missed therapy time was due to patient fatigue. We know that patients who have suffered from strokes, traumatic brain injury and multiple sclerosis may complain of significant levels of fatigue (2–6), which itself can be subdivided into cognitive and motor components. Assessment of fatigue is difficult and may be confounded by other symptoms such as weakness, spasticity, cognitive impairment and depression.

Pharmacological approaches to reduce fatigue in the neurological population studied have produced variable results, but if solutions to the important issue of fatigue and its potential consequences such as lost therapy time can be found, these will

undoubtedly enhance neurorehabilitation for the patient and therapist alike.

REFERENCES

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Submitted December 5, 2002; Accepted September 30, 2003

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In Response to the Letter to the Editor by Paul

We were mindful of the fact that intensive therapy might cause fatigue in the experimental group and so data was collected on the reasons for missed therapy to ascertain whether fatigue was the cause.

Missed therapy was divided into 4 categories: refused treatment; staff cancelled treatment; unable to attend; and too tired or ill to attend.

- *Refused treatment* was used if patients did not want to attend for any reason other than fatigue or illness, e.g. they had visitors.
- *Staff cancelled* was used if staff were ill or had to attend meetings, etc.
- *Unable to attend* was used when patients were unable to attend for therapy because they needed to be seen somewhere else, i.e. MRI scan, etc.

- *Too tired or too ill* was used if the patient could not or would not attend because of fatigue or illness.
- Only 13.5% of missed therapy was attributable to the patients being fatigued or ill, and this was not significantly different between groups (experimental 13% and control 14%).

Thus there would seem to be only limited opportunity to improve management by improving fatigue. Nevertheless this is an important impairment associated with many neurological disorders and clinical management should always consider the impact of fatigue on the rehabilitation process.

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