Letter by Freeman et al Regarding Article, “Very Early Mobilization After Stroke Fast-Tracks Return to Walking: Further Results From the Phase II AVERT Randomized Controlled Trial”

To the Editor:

We read with great interest the article by Cumming et al regarding the AVERT trial on early mobilization in acute stroke patients within 24 hours of onset of symptoms. Early mobilization after acute stroke can improve patient care by starting physical therapy earlier and by potentially reducing deep venous thrombosis risk and hospital length of stay. The authors demonstrate relative safety and improved odds walking 50 meters unassisted compared to a control group. What is not clear from the AVERT trial is how many patients had early mobilization after thrombolysis. We performed mobilization between 12 and 24 hours after tissue plasminogen activator in acute ischemic stroke patients treated with intravenous tissue plasminogen activator at Mayo Clinic Florida between February and July 2010, and we found similar physiological safety in 9 out of 10 patients (ie, no hemorrhagic complications, hemodynamic compromise, orthostatic hypotension, tachycardia, adverse symptoms, or worsening stroke deficits). Only one 91-year-old patient had asymptomatic orthostatic hypotension. We did not use walking distance as our end point as in the AVERT trial, instead safety was our primary end point, and hospital length of stay was used as a secondary end point. There was no significant difference in average length of stay in the early mobilization group (<24 hours from tissue plasminogen activator administration) compared to a control group mobilized 24 hours after tissue plasminogen activator (3.11 versus 3.56 days; \( P = 0.685 \)). We are interested to know how the subgroup of patients after thrombolysis did in the study. Current guidelines recommend consideration of early mobilization in less severely affected patients. Early mobilization within 24 hours beginning at 12 hours after tissue plasminogen activator may have similar benefit as the AVERT data suggest on poststroke functional recovery. We suggest future studies explicitly explore subgroups of patients with acute ischemic stroke with and without thrombolysis while evaluating safety, optimal timing of rehabilitation (<12 hours, >12 hours, or >24 hours), and the effects of such intervention on poststroke functional recovery.

Disclosures

None.

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