Critique of A Very Early Rehabilitation Trial (AVERT)

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Based on a large multicenter/intercontinental patient population, the A Very Early Rehabilitation Trial (AVERT) suggests that early intensive mobilization procedures negatively affect 3-month outcome in severely affected stroke victims and in patients with intracerebral hemorrhage. This unexpected finding is interpreted in view of the limitations of the trial. It is argued that these results should not lead to prolonging immobilization and inactivity after stroke and to a cessation of clinical research that aims at integrating rehabilitation intervention into acute stroke care.

The AVERT trial is the largest randomized multicenter trial conducted in stroke rehabilitation to date. It compares very early mobilization within 24 hours after symptom onset with usual care in patients with ischemic or hemorrhagic stroke. The trial compares a group of 1042 patients mobilized after 22.4 hours (16.5–29.3) versus 1036 patients mobilized after 18.5 hours (median; IQR, 12.8–22.3) versus 1036 patients mobilized after 22.4 hours (16.5–29.3).

The results are unexpected—as the authors admit—in that they lead to rejection of their hypothesis that very early mobilization is superior to usual care. The findings suggest that early rehabilitation may be worse than usual care fueling a phase 2 trial conducted by the same group. The generalizability of the finding (external validity of the trial) can be regarded as good despite the fact that only 6% of subjects screened were actually recruited. The main reason for exclusion was late arrival to the hospital, representing one of the greatest obstacles to successful stroke treatment in general. The superiority of later and less intense mobilization found in AVERT may prompt stroke physicians to reverse the tendency of integrating rehabilitation into acute stroke care. Patients may be kept immobile and inactive for several days after stroke.
prolonged period of time, which may be tempting because of a reduction of workload on busy wards. This is dangerous. Delayed mobilization is not only associated with complications. Muscle wasting and disuse-related neural adaptations will create a significant problem when rehabilitation is eventually started at a later stage. One also has to realize that patients can be kept active without necessarily taking them out of bed. Several devices and therapy methods exist for this purpose.

This danger of falling into the opposite extreme of immobilization and inactivity now raises the question whether the AVERT intervention was ready for testing in a large trial thereby accepting the possibility of a negative outcome. Were therapy protocols and patient selection optimized to enter the scrutiny of a trial? Changes in blood pressure observed with verticalization after stroke are a frequent problem and need special procedures and technology to be prevented. In addition, mobilization may have even been delivered too late in AVERT considering that the negative effect of early intense mobilization was not observed in the 374 patients mobilized within 12 hours. This is not a critique of AVERT, which provides an important and valuable data set and results. It is a pledge not to stop here and neglect further clinical research on early mobilization and activation.

In conclusion for clinical practice, AVERT provides a signal to suggest that very early mobilization within 24 hours after stroke has to be considered with caution and should be avoided in those who are severely affected or had intracerebral hemorrhage. The cause of bad outcome after early and intense mobilization may be stroke progression, which was the adverse event with the largest between-group differences in survivors and nonsurvivors alike.

Disclosures

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References


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