

## REHABILITATION & RECOVERY

2408

### Causes and mechanisms of development of vascular parkinsonism after ischemic stroke

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**Background and aims:** In most cases, ischemic and hemorrhagic strokes are the main cause of vascular parkinsonism. The purpose of our work is to determine the degree of development of vascular parkinsonism after strokes.

**Methods:** In order to determine the level of development of vascular parkinsonism after strokes, we analyzed 123 patients who had ischemic strokes during our study. The mean age of the patients was 64.4±4.4, motor and non-motor symptoms of parkinsonism were compared in all patients. Patients were analyzed by gender. The first group consisted of 62 male patients, and the second group consisted of 61 female patients. The obtained data were statistically analyzed.

**Results:** It was found that the first group of patients had more rigidity, hypokinesia ( $p < 0.05$ ) than the second group, and the second group had more tremors than the first group ( $p < 0.01$ ). Plastic hypertonus was observed in male patients compared to female patients. Memory impairment was observed in 56% of male patients and 46% of female patients. When patients with parkinsonism syndrome were examined by MRI angiography, it was found that all of these patients had narrowing of the right middle cerebral artery ( $p < 0.01$ )

**Conclusions:** we can conclude that ischemic stroke is the cause of the development of vascular parkinsonism, the main cause of which is a violation of blood circulation in the middle cerebral artery, vascular parkinsonism is more common in male patients than in women, in the early periods after ischemic stroke restoration of blood circulation reduces the likelihood of developing vascular parkinsonism.

**Disclosure of interest:** No

## REHABILITATION & RECOVERY

2449

### Long-term Outcome and Health-Related Quality of Life for People with Aphasia after Ischemic Stroke

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**Background and aims:** Knowledge regarding long-term outcome of aphasia and health-related quality of life (HRQoL) is needed to individualize rehabilitation for people with aphasia after ischemic stroke.

**Methods:** Consecutive patients with first-ever ischemic stroke admitted to Skåne University Hospital, Sweden were screened for aphasia at baseline (median day 4) with the Language Screening Test. At 1, 3, and 12 months after stroke onset people with aphasia (PWA) were evaluated with the Comprehensive Aphasia Test (CAT) concerning language and cognitive function. HRQoL was assessed with the self-reported Aphasia Impact Questionnaire (AIQ). We analyzed outcome of aphasia and associations between aphasia severity, stroke severity (NIHSS), and HRQoL.

**Results:** In the acute phase of stroke, 27% presented with aphasia ( $n=60$  of 221). At 1 month after stroke onset, 74% ( $n=40$  of 54 survivors with initial aphasia) had remaining aphasia, at 3 months 67% ( $n=34$  of 51) had aphasia and at 12 months post stroke 61% ( $n=30$  of 49) had remaining aphasia. At 12 months post stroke aphasia negatively affected communication (90%), participation (77%) and emotional well-being (83%) for PWA. HRQoL was significantly associated with aphasia severity even after adjusting for stroke severity and age.

**Conclusions:** Chronic aphasia was observed in 61% of all alive patients with baseline aphasia. Aphasia severity impacts HRQoL regardless of stroke severity. Aphasia continues to have large negative consequences for stroke patients.

**Disclosure of interest:** No

## REHABILITATION & RECOVERY

2644

### FEASIBILITY OF A SELF-MANAGEMENT INTERVENTION FOR IMPROVING MOBILITY FOR PATIENTS FOLLOWING STROKE IN THE COMMUNITY

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**Background and aims:** Self-management interventions have the potential to help stroke survivors to manage their rehabilitation after discharge from acute care. The aim of this study is to examine the feasibility of a self-management intervention to improve mobility in the community for stroke survivors.

**Methods:** A mixed methods design was used (a pilot randomised controlled trial and focus groups). Participants were adult stroke survivors within six months post stroke, with functional and cognitive ability to participate in self-management programmes. The intervention included education sessions, goal setting and action planning, group sessions, self-monitoring and follow up. The Control group received only education sessions. Participants assessed at baseline, three months and six months. The primary outcomes included feasibility outcomes and the secondary