The effect of global postural reeducation technique in a hemiparetic stroke patient

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ABSTRACT

The most evident motor dysfunction in the Cerebrovascular Accident (CVA) is hemiparesis. Hemiparetic patients have a tendency to maintain an asymmetric posture. The aim of this study was to evaluate the posture in a hemiparetic stroke patient using the Global Postural Reeducation (GPR) technique. The participant was a right hemiparetic patient due to a CVA that had taken place 5 years before; his cognitive state was good, according to the Mini-Mental State Examination test and he presented moderate motor impairment. The postural evaluation was performed by a computer program, called FisioLogic. The patient underwent a treatment plan comprising ten sessions of GPR technique during eight weeks. Although the treatment was carried out with emphasis on the pelvic inclination and the scapula positioning, the results also showed improvement regarding the support base and, according to the patient, it also improved his balance and gait. We conclude that the GPR technique yielded positive results regarding the posture pattern of the hemiparetic patient.

KEY-WORDS
postural evaluation, cerebrovascular accident, hemiplegia, body image, rehabilitation

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Introduction

The cerebrovascular accident (CVA) or stroke results from a restriction in the blood flow to the brain, causing cellular lesion and damage to the neurological functions. Clinically, several deficiencies are possible, including damage to motor, sensitive, mental, perceptive and language functions. The most evident motor dysfunction in stroke is hemiparesis; whatever the cause of the stroke is, it is characterized by the loss of motor control in one side of the body. Hemiparesis results in an extremely important loss of the selective activity of the muscles that control the trunk, particularly the muscles responsible for flexion, rotation and lateral flexion. The most evident impairment is the tendency to maintain oneself in a position of postural asymmetry, with a lower distribution of weight on the paretic hemibody. This asymmetry and the difficulty to transfer the weight to the affected side interfere with the individual’s capacity to maintain postural control, preventing orientation and stability to perform movements with the trunk and limbs, which can result in falls. In hemiparesis, the abdominal muscles show a remarkable loss of activity and tonus. The umbilical scar is pulled onto the non-affected side. The entire abdominal wall has a hypotonic appearance. In the sitting position, the lateral wall is projected with laxity above the pelvis in the affected side. In both postures, sitting and standing, when viewed from behind, the distance from the vertebral column to the lateral border of the trunk is longer in the affected when compared to the non-affected side. In normal postural alignment there is a slight protrusion of the head with level shoulders, and the vertebral column has a series of counterbalanced anteroposterior curves, such as cervical and lumbar lordosis and thoracic and sacral kyphosis. The pelvis must be in a neutral position, defined by the alignment in a transversal plane, of the anterosuperior with the posterosuperior iliac spine. The weight load on the lower limbs must be equally distributed, a characteristic obtained through the harmony among the antigravitational muscles. There is a prevalence of postural deficits in patients with left hemiparesis in opposition to patients with right hemiparesis, as demonstrated by clinical and instrumental studies that have shown that left hemiparetic patients have less postural balance in sitting and standing positions in comparison to right hemiparetic patients, and that there is a high degree of postural abnormalities in hemiparetic patients with neglect.

Umphred describes the perceptive deficits of right and left hemiparesis. In left hemiparesis, general global spatial deficits are common, such as the visual-perceptive, behavioral and intellectual ones. The patient can present a disorder in self/body image, impairment of self-correction, difficulty to retain information, irritability and confusion, among others. In right hemiparesis, one can observe language deficits and apraxia, whereas regarding behavior and intellectual deficits, one can observe mainly the difficulty to start tasks and deficits in giving sequence to and the rapid performance of movements or activities.

Many brain structures are involved in postural recovery after a stroke: the cerebellum, especially the vestibulocerebellum (flocculo-nodular lobe) and the paleocerebellum, basal ganglia and the cortex, mainly the posterior parietal region in both sides. The right posterior parietal cortex seems to be predominantly involved with spatial integration, as shown by the prevalence of visual-spatial deficits in lesions occurring on this side. The visual-spatial information is crucial for posture recovery. For patients who suffered a stroke, the recovery of the ability to stand and walk is critical, as it requires a complex mechanism of postural control, which has yet to be completely understood. Several strategies are suggested for maintaining postural control. For the treatment of postural deficits, Physical therapy has a technique called Global Postural Reeducation (GPR). GPR is a technique that considers the muscular, sensory and skeletal systems as a whole and tries to treat muscles individually. GPR is basically a proprioceptive method of inhibition. The proprioceptive stimulus deals with the reeducation of the postural balance, promoting stability, reeducation of the vestibular and visual apparatus and perfecting the reactions of straightening and balance.

The treatment consists of decubitus and load postures. These comprehend the GPR “exercises”, stretching together with breathing exercises. These postures simultaneously perform isometric work, that of the static muscles and the dynamic work, always with a progressive joint decoaptation, which becomes increasingly more global. The aims of the study were to evaluated and treat the postural alterations in a patient with hemiparesis due to a stroke, using the GPR technique and emphasize the treatment in two variables: pelvic inclination and scapular positioning.

Case Report

M. S., a 40-yr-old male patient, with a diagnosis of right hemiparesis after a ischemic stroke, with a 5-year history of lesion, good cognition according to the Mini-Mental State Examination test with a score of 23, stage 4 of Brunnstrom rehabilitation, was undergoing treatment at the Physical Therapy Clinic of Mogi das Cruzes University (Universidade de Mogi das Cruzes - UMC).

Regarding the motor capacity, the patient presented spastic hypertonia, according to the modified Ashworth Scale: grade one (1) in shoulder extenders, grade 1+ in shoulder abductors and grade 2 in adductors; grade 2 in elbow extensors and grade 2 in hip extendors, grade 1+ in knee flexors and grade 1 in planter flexors. Regarding the transpostural changes, he presented a deficit of balance at the cat posture with decrease of weight unload on the affected hemibody. As for the posture in the orthostatic position, he presented head anteriorization, thoracic hyperkhiphosis, lumbar hyperlordosis, slightly anteverted hips, varus knees with internal rotation of the femur and pronated feet, and in an anteroposterior view, he presented trunk inclination to the left.

The postural assessment was performed through the postural analysis software – FisioLogic, which has been validated in some
studies. This program allows the professional to obtain the coordinates x and y of the body markers in pixels; these coordinates are used to later calculate the values of body segments.

For the photographic analysis it is necessary to define the protocol of the program evaluation. The points to be studied in the patient are defined, and the segments of interest must be determined based on such points.

The material used was a Neurological and Postural Assessment File, styrofoam markers (2.5 cm of diameter), dotted board, digital camera (Olympus, model D560), specific table for GPR, bench (for sitting), supports, Velcro straps and the Mini-Mental State Examination test.

**Procedure**

The research was approved by the Ethics and Research Committee of Universidade de Mogi das Cruzes (process #154-2005; CAAE 0118.0.237.000-05). After informed consent, the patient was assessed through a neurological and postural evaluation as well as with the Mini-Mental State Examination test, followed by the digital photographic recording before and after treatment.

The photographic recording was carried out in the anterior, posterior and right and left lateral views, at a distance of 2 meters, after the fixation of styrofoam markers on the anatomic points on the patient’s skin (occipital fossa, spinous process C7, acromions, lower and upper scapular angles, ulnar styloid processes, upper anterior and posterior iliac spines, spinous process L5, fibular heads and lateral malleolus).

It was suggested to the patient to maintain the lower limbs close to each other during the evaluation, as long as possible.

After the initial evaluation, 10 sessions were scheduled, divided in 8 weeks with a mean duration of one hour each.

**Treatment**

The postures chosen for the treatment were: the dorsal decubitus posture, the frog-like posture (opening of the coxofemoral angle) (Figure 1), sitting (closure of the coxofemoral angle) and standing against the wall (opening of the coxofemoral angle).

In the frog-like posture (Figure 1), the patient remains in dorsal decubitus, with upper limbs in abduction and the palms of the hands turned upward, relaxed between the patient’s skin (occipital fossa, spinous process C7, acromions, lower and upper scapular angles, ulnar styloid processes, upper anterior and posterior iliac spines, spinous process L5, fibular heads and lateral malleolus).

It was suggested to the patient to maintain the lower limbs close to each other during the evaluation, as long as possible.

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**Evolution**

According to the Table 1, the anterior view photographic analysis, we observed that the most evident alteration was the distance measured between the points of the right and left malleoli, going from 39.2 to 18.5 cm with a decrease of 20.7 cm, which is the size of the static support base. The decrease of the support base was also demonstrated by the measurement between the right and left fibulae, which showed a reduction of 9.6 cm of distance; before treatment, this distance was 36.4 cm and decreased to 26.8 cm.

In the upper limb, the distance between the right and left ulnar styloid processes before and after the technique was applied, was 53.9 cm and 63.2 cm, respectively, with a gain of 9.3 cm; the less evident alteration was the distance between the right and the left acromion, which decreased 0.7 cm.

Taking the vertical line of the dotted chart as reference in order to assess the positioning of the trunk, we observed the difference in
the line from the right acromium to the right iliac spine, which was 49.5 cm and increased to 55.8 cm, with a gain of 6.3 cm, and the distance between the left acromium and the left iliac spine, which went from 52.7 to 57.9 cm, with a gain of 5.2 cm.

As shown in Table 2, the photographic analysis of the right lateral view, there was an alignment of the posture, improving the position of the head in relation to the midline. There was a relative decrease in the head anteriorization demonstrated by the alteration of the angle of the occipito-C7 segment to the vertical line, which decreased 2.9°.

Table 1
Photographic postural evaluation of the anterior view.

<table>
<thead>
<tr>
<th>Name</th>
<th>Measurement 1 06/07/05</th>
<th>Measurement 2 30/09/05</th>
<th>Ideal</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iliac spine</td>
<td>2.8 °</td>
<td>0.9 °</td>
<td>0.0 °</td>
<td>Angle of the segment of the iliac spine in</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>relation to horizontal line</td>
</tr>
<tr>
<td>Fibular head</td>
<td>0.5 °</td>
<td>-1.1 °</td>
<td>0.0 °</td>
<td>Angle of the segment of the fibular heads in</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>relation to horizontal line</td>
</tr>
<tr>
<td>Acromiums</td>
<td>34.9 cm</td>
<td>34.2 cm</td>
<td>34.9 cm</td>
<td>Distance of the point of Right acromium to</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>the Left acromium</td>
</tr>
<tr>
<td>Styloid process</td>
<td>53.9 cm</td>
<td>63.2 cm</td>
<td>63.2 cm</td>
<td>Distance of the point of R styloid process to</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>L styloid process</td>
</tr>
<tr>
<td>Malleolus</td>
<td>39.2 cm</td>
<td>18.5 cm</td>
<td>18.5 cm</td>
<td>Distance of the point of R malleolus to L</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>malleolus</td>
</tr>
<tr>
<td>Fibula</td>
<td>36.4 cm</td>
<td>26.8 cm</td>
<td>26.8 cm</td>
<td>Distance of the point of R fibula to L fibula</td>
</tr>
<tr>
<td>AcromiumR spine</td>
<td>49.5 cm</td>
<td>55.8 cm</td>
<td>55.8 cm</td>
<td>Distance of the point of R acromium to R</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>iliac spine</td>
</tr>
<tr>
<td>AcromiumL spine</td>
<td>52.7 cm</td>
<td>57.9 cm</td>
<td>57.9 cm</td>
<td>Distance of the point of L acromium to L</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>iliac spine</td>
</tr>
</tbody>
</table>

Therefore, an increase of 0.2 cm in the distance of the occipital segment to C7 was also shown, as well as in the distance of the segment C7-L5, which increased 7.3 cm. In the upper limbs, the segment of the right acromium to the styloid process of the right ulna had an increase of 11.3 cm.

The angle of the segment corresponding to the posterosuperior iliac spine in relation to the horizontal line decreased 2.1°.

The angulation of the point of the right fibula to the right malleolus in relation to the vertical decreased 0.5°, approximating it to the vertical line.

The improvement in the positioning of the shoulders can also be observed in the posterior view, through the improvement in the alignment of the acromial and scapular line. The acromial line presented a 2.0° inclination before, and after treatment, this angle was reduced to 0.0°; the same occurred with the scapular line, measured through the inferior angle of the scapulae, which presented an inclination of 1.4° and was also reduced to 0.0° after treatment.

Discussão
Postural alterations are frequent in patients with hemiplegia, and limit or impair the recovery of gait and functional independence. This fact makes postural control a rehabilitation priority after a stroke.

The correction postures employed in the Global Postural Reeducation technique are the result of the joint decoaptation through the therapist’s manual action and the stretching of shortened muscle tissues.
they also observed positive results regarding the patient’s postural pattern, such as a better head positioning and improvement in the dorsal kyphosis.

In this study, the stretching of the anterior chain muscles can justify the improvement in the positioning of the right upper limb. Comparing the results of the treatment, it can be observed that the patient presented shoulder adduction with elbow, wrist and finger flexion in the affected hemibody, and after the therapeutic intervention, the patient maintained the upper limb was kept aligned in neutral position with reduction of the elbow flexion.

According to Umphred, the hemiparetic patients present spasticity of the trunk musculature, especially in the shoulder and the pelvic girdle, resulting in a pattern of downward rotation of the scapulae and upward inclination of the pelvis, which can cause the trunk in the affected side to appear laterally flexed.

With the development of the postures used in the treatment, an improvement in trunk alignment could be observed, demonstrated by the increased distance between the right acromion and the right iliac spine, and by the increased distance from the scapula to the posteroanterior iliac spine, which resulted in an improvement of the lateral flexion of the trunk in the hemiparetic side.

Paillex & So in their study, evaluated a heterogeneous group of hemiplegic individuals and showed improvement in the standing posture through the decrease of the lateral displacement of the center of pressure after the rehabilitation period. The authors hypothesized that the main component of this result was the decrease of tension in hip adductors and abductors.

During the performance of the standing against the wall posture, the patient was induced to concentrate the body weight on the right lower limb, as it was necessary to maintain a central body alignment. The patient performed the posture with the therapist’s help. Pai et al. state that the methods used to improve posture, balance and gait in hemiparetic adults have typically emphasized activities that facilitate support and weight transference in the affected lower limb.

According to the results of the present study, it was observed that, even after treatment, the patient still maintained trunk alignment that was concentrated on the healthy hemibody, which meant that the weight transference was still more significant for the left hemibody.

According to the patient’s report, he attained balance and consequently, gait improvement, and when inquired about trunk positioning before and after treatment, the patient had the body perception to realign it in front of the mirror, which can mean body awareness improvement. The fact that he was a right hemiparetic patient might have influenced these results. According to Chagas and Tavares, right hemiparetic patients present better functional capacity, especially in activities that involve orthostatism, balance and gait. In the left hemiparetic, the areas involved in the body system that are related to the function of spatial perception are affected, and that can lead to a neglect condition of the impaired hemibody.

The data obtained on body awareness, balance and gait were based entirely on the patient’s report.

<table>
<thead>
<tr>
<th>Name</th>
<th>Measurement</th>
<th>Ideal</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C7/L5</td>
<td>5,5°</td>
<td>2,9°</td>
<td>Angle of C7/L5 segment in relation to vertical</td>
</tr>
<tr>
<td>Post. Iliac spine/Ant. Iliac spine</td>
<td>171,3° 169,2°</td>
<td>0,0°</td>
<td>Angle of the iliac spine segment – Post. to vertical</td>
</tr>
<tr>
<td>Occipto/ C7</td>
<td>17,9°</td>
<td>15,3°</td>
<td>Angle of the occipto/C7 segment in relation to vertical</td>
</tr>
<tr>
<td>Ant. iliac spine/ fibula</td>
<td>-16,5°  -15,8°</td>
<td>0,0°</td>
<td>Angle of the ant. iliac spine/ fibula segment in relation to vertical</td>
</tr>
<tr>
<td>Fibula/ malleolus</td>
<td>-1,7°</td>
<td>-1,2°</td>
<td>Angle of the fibula/ malleolus segment in relation to vertical</td>
</tr>
<tr>
<td>Occipto/ C7</td>
<td>6,5 cm</td>
<td>6,7 cm</td>
<td>Distance from the occipital point to C7</td>
</tr>
<tr>
<td>C7/L5</td>
<td>50,4 cm</td>
<td>57,7 cm</td>
<td>Distance from C7 to L5</td>
</tr>
<tr>
<td>Acromium/styloid process of the ulna</td>
<td>59,7 cm</td>
<td>71,0 cm</td>
<td>Distance from Acromium to Styloid process of the ulna</td>
</tr>
</tbody>
</table>
Conclusion

The Global Postural Reeducation (GPR) technique presented positive results in this patient who became hemiparetic after a stroke. No improvement in the patient’s postural pattern was observed, as well as alignment of the acromions and scapulae, indicating a decrease in shoulder asymmetry, improvement of the dorsal kyphosis and decrease of support base.

There have been no reports in literature regarding the use of GPR technique in patients with hemiparesis; however, for this right hemiparetic patient who presented good cognition and moderate motor impairment, this showed to be a promising therapy.

Although the study disclosed good results regarding the posture of the hemiparetic patient, it would be necessary to carry out further studies to correlate the posture treatment with some type of functional activity, with a larger number of sessions and participants.

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References