

2016

A randomized controlled trial of very early rehabilitation in speech after stroke

Erin Godecke
Edith Cowan University

Elizabeth Armstrong
Edith Cowan University

Tapan Rai

Sandy Middleton

Natalie Ciccone
Edith Cowan University

See next page for additional authors

Follow this and additional works at: <https://ro.ecu.edu.au/ecuworkspost2013>



Part of the [Medical Neurobiology Commons](#), and the [Speech Pathology and Audiology Commons](#)

[10.1177/1747493016641116](https://doi.org/10.1177/1747493016641116)

This is an author's accepted manuscript of:

Godecke, E., Armstrong, E. A., Rai, T., Middleton, S., Ciccone, N., Whitworth, A., ... & Cadilhac, D. A. (2016). A randomized controlled trial of very early rehabilitation in speech after stroke. *International Journal of Stroke*. 11(5), 586-592.

<https://doi.org/10.1177/1747493016641116>

This Journal Article is posted at Research Online.

<https://ro.ecu.edu.au/ecuworkspost2013/1933>

Authors

Erin Godecke, Elizabeth Armstrong, Tapan Rai, Sandy Middleton, Natalie Ciccone, Anne Whitworth, Miranda Rose, Audrey Holland, Fiona Ellery, Graeme Hankey, Dominique Cadilhac, and Julie Bernhardt

Title

A randomised controlled trial of Very Early Rehabilitation in Speech (VERSE) after stroke.

Authors

Erin Godecke¹, Elizabeth Armstrong¹, Tapan Rai², Sandy Middleton³, Natalie Alison Ciccone¹, Anne Whitworth⁴, Miranda L. Rose⁵, Audrey Holland⁶, Fiona Ellery⁷, Graeme J. Hankey⁸, Dominique Cadilhac⁹, Julie Bernhardt¹⁰.

¹ *Edith Cowan University, Perth, Western Australia, Australia*

² *University of Technology Sydney, Sydney, New South Wales, Australia*

³ *St Vincent's & Mater Health Sydney and Australian Catholic University, Australia*

⁴ *Curtin University of Technology, Perth, Western Australia, Australia*

⁵ *La Trobe University, Melbourne, Victoria, Australia*

⁶ *University of Arizona, Tucson, Arizona, USA*

⁷ *Neuroscience Trials Australia, Melbourne, Victoria, Australia*

⁸ *School of Medicine and Pharmacology, The University of Western Australia, Perth, Western Australia, Australia*

⁹ *Monash University, Melbourne, Victoria, Australia*

¹⁰ *The Florey Institute of Neuroscience and Mental Health, Melbourne, Victoria, Australia*

Corresponding Author details

Erin Godecke (PhD)

School of Psychology and Social Sciences

Edith Cowan University

270 Joondalup Dve

JOONDALUP Western Australia 6027 T +61 8 6304 5901

e.godecke@ecu.edu.au

Abstract

Rationale: The efficacy of rehabilitation therapy for aphasia caused by stroke is uncertain.

Aims and Hypothesis: The Very Early Rehabilitation of Speech (VERSE) trial aims to determine if intensive prescribed aphasia therapy (VERSE) is more *effective* and *cost saving* than non-prescribed, intensive (Usual Care-Plus) and non-intensive usual care (UC) therapy when started within 15 days of stroke onset and continued daily over four weeks. We hypothesise that aphasia therapy when started very early after stroke and delivered daily could enhance recovery of communication compared with usual care.

Sample size estimates: 246 participants (82 per arm) will provide 80% power to detect a 4.4% improvement on AQ between VERSE and UC plus at a significance level of $\alpha = 0.05$.

Methods and design: Setting: Acute-care hospitals and accompanying rehabilitation services throughout Australia, 2014-2017.

Design: Prospective, randomised, parallel group, open-label, blinded endpoint assessment (PROBE) trial.

Participants: acute stroke in previous 14 days and aphasia diagnosed by Aphasia Quotient (AQ) of the Western Aphasia Battery (WAB).

Randomisation: Computer-generated blocked and stratified randomisation procedure by aphasia severity according to WAB, to one of three arms.

Intervention: All participants receive Usual care (UC) - usual ward based aphasia therapy. Arms 2 and 3 receive a total of twenty additional sessions (45-60 minutes, provided daily) of aphasia therapy. *Arm 1:* Usual Care (UC) - (no additional therapy); *Arm 2:* UC-Plus usual ward based therapy; *Arm 3:* VERSE therapy - a prescribed and structured aphasia therapy program. The additional intervention must be provided before day 50 post stroke.

Study outcome measures: the AQ of WAB at 12 weeks post-stroke. Secondary outcomes include discourse measures, the Stroke and Aphasia Quality of Life Scale-39 (SAQoL-39) and the Aphasia Depression Rating Scale (ADRS) at 12 and 26 weeks. Economic evaluation: Incremental cost-effectiveness ratios at 26 weeks will be reported.

Discussion: This trial is designed to test whether the intensive and prescribed VERSE intervention is effective in promoting maximum recovery and preventing costly health complications in a vulnerable population of survivors of stroke. It will also provide novel, prospective, aphasia specific cost-effectiveness data to guide future policy development for this population.

Introduction and Rationale

Aphasia affects approximately a third of the 440,000 individuals living with stroke in Australia [1]. Recovery from aphasia is highly variable with multiple factors believed to contribute to the overall extent of communication recovery achieved by each individual[2]. There are currently few available specific medical treatments designed to reduce the impacts of aphasia occurring as a consequence of stroke, therefore aphasia rehabilitation is the mainstay of recovery for people with aphasia.

Early aphasia rehabilitation is thought to enhance the natural processes of spontaneous recovery by strengthening neural networks through the use of highly repetitious, task-specific behaviours that require coinciding neuronal firing of a group of connected neurons[3]. These behaviours are believed to minimise independent neuronal activation that may produce maladaptive behaviours[3].

The 2012 Cochrane Review examined 39 trials of aphasia therapy following stroke and found no Level 1 evidence[4] for the efficacy of aphasia treatments in the long-term. There was *some* evidence that speech and language therapy (SLT) was more effective than no SLT however caution is required when interpreting the Cochrane Review[4] results as many studies were comparative in nature, lacked adherence to the CONSORT statement[5] and demonstrated inferior design quality[4]. Additionally, little is known about the costs of available treatment options.

Aims and Hypotheses

VERSE aims to determine if intensive aphasia therapy provides greater efficacy and is at least cost-effective when compared to usual ward based rehabilitation (UC) at 12 weeks post stroke, when therapy is commenced within the first fifteen days post stroke. Aphasia therapy in this trial refers to direct impairment-based aphasia treatment in contrast to other communication therapy, case-management, patient/family counselling and education.

Our primary hypothesis is that compared to UC, early intensive aphasia therapy will result in improved communication ability, determined by at least a 20% greater score on the (AQ) of the (WAB)[6] at 12 weeks post stroke.

Secondary hypotheses:

- i) VERSE aphasia therapy will result in a 4.4% greater score on the AQ when compared to UC-*Plus* aphasia therapy at 12 and 26 weeks post stroke.
- ii) Very early intensive aphasia therapy will result in better quality of life using SAQoL – 39 at 12 and 26 weeks post stroke than UC control.
- iii) Very early intensive aphasia therapy will be more cost-effective than UC at 26 weeks post stroke.

VERSE is a three-armed prospective, single-blinded multicentre, randomised controlled trial with primary outcome 12 weeks and follow-up at 26 weeks post-stroke (see Figure 1) and intention to treat analysis.

Patient Population

Approximately 16 acute care hospitals and related rehabilitation services in Australia and New Zealand will be involved. Participants include acute stroke patients (>18 years) with aphasia (AQ score <93.7) who are otherwise medically stable, who provide consent, and are assessed and randomised by the baseline assessor within 14 days of stroke. See Table 1 for inclusion and exclusion criteria.

Methods

The intervention is provided by qualified and trained speech pathologists for a maximum of 25 working days, commencing the day after baseline assessment and randomisation (see Figure 2). Participants and families in addition to staff not involved in providing the intervention to participants are blinded to group allocation.

Randomisation

Participants are stratified by baseline aphasia severity, (AQ scores mild: 62.6 – 93.7, Moderate: 31.3 – 62.5 and severe: 0 – 31.2) and then randomised to one of three groups. The randomisation schedule was created by an independent statistician, using a computer-generated permuted blocked procedure and allocation ratio of 1:1:1. Participants are randomise via a web based electronic data collection system. (REDCap™)[7].

Intervention

ARM 1: Usual Care (UC)

Participants will receive usual care alone. UC speech pathologists will be responsible for all speech pathology services including case management, education, counselling and any co-occurring dysphagia management for all trial participants. We have anticipated the intensity of UC direct aphasia therapy to be *less than 6 hours in total* based on our previous work [6,8].

ARM 2: Usual Care – Plus (UC-Plus)

In addition to usual care, the UC-Plus group will receive aphasia therapy that is determined by the treating therapist; at the prescribed regimen:

(a) between 45-60 minutes of 1:1 therapy 5 days per week for 20 sessions (15-20 hours) (within a maximum of 25 working days)

(b) a minimum of 3 and a maximum of 5 sessions per week

ARM 3: VERSE Therapy

The VERSE aphasia therapy intensity and timing of commencement of intervention will match the UC-Plus group however the VERSE treatment is prescribed by an Intervention Protocol provided only to the trained VERSE therapists and is designed for all aphasia types and severity levels.

Therapists complete a daily therapy log in an electronic Case Report Form (eCRF) REDCap[7] for each participant including content, duration and frequency of all therapy sessions. UC-Plus and VERSE sessions will be video recorded, monitored and cross-referenced with information provided in the eCRF. Deviations from the VERSE protocol will be addressed with the clinician.

Required study assessments and the assessment timeline are outlined in Table 2.

All outcome assessments will be carried out by qualified and study trained speech pathologists who are independent blinded assessors. Information relating to resource utilisation will be obtained from the participant.

Participants will be assessed for adverse events (AEs) throughout this trial. All AEs reported during the intervention period (between consent and 50 days post stroke), will be reported. AEs that relate to the new diagnosis or worsening of clinical depression will be reported up to week 26.

AEs that meet the criteria for serious, (SAEs) will be reported for the duration of the project. Trial therapists and blinded assessors staff will identify and report events and reviewed by a medical monitor and independent Data Safety Monitoring Committee.

Primary Outcome

The primary outcome is the AQ score of the WAB assessed by a blinded assessor at 12 weeks post stroke. The WAB is considered a reliable measure of severity of language impairment and is sensitive to change [6].

Secondary Outcomes

These are assessed by a blinded assessor and include;

Health related Quality of life as determined by SAQoL- 39[10] at 12 and 26 weeks

Resource Utilisation at 26 weeks. Participant provided services will be collected at 12 and 26 weeks by the blinded assessor. Information will be used to estimate the cost effectiveness of VERSE therapy compared to UC and UC-plus. Amount and type of inpatient and outpatient rehabilitation, length of acute hospital stay, discharge destination, hospital readmissions, general practitioner visits, community and health care service use, medication use, respite and informal care services and any speech and communication aids/devices changes in employment status and services utilised as a result of the stroke will be collected.

Sample Size

A sample of 246 participants will provide 80% power to detect this difference at a (two-tailed) significance level of $\alpha = 0.05$, after adjusting for 5% non-adherence and a loss to analysis of 12% (due to death and dropout).

Statistical Analysis

An intention-to-treat analysis will be used. A secondary per protocol analysis will explore dose related differences in the primary outcome.

Primary analysis

This will be a between-group comparison of recovery on AQ at 12 weeks. A generalized estimating equations model will be developed to analyse difference in recovery between groups. Differences in baseline AQ scores and baseline National Institute of Health Stroke Scale

(NIHSS)[8] will be included as covariates in the model. The intervention effect will be represented as the difference in percent of maximal potential recovery achieved.

Secondary analyses

The generalised estimating equations model developed for the primary analysis will also examine differences in recovery on AQ between the three groups (VERSE, UC-plus and UC) and to assess whether these differences are sustained at 26 weeks.

A generalized estimating equations model will be developed to analyse differences between the three groups (VERSE, UC-Plus and UC) in recovery of connected speech (Discourse measures) at 12 weeks and 26 weeks. Baseline AQ scores and baseline modified Rankin Score[9], will be controlled for by including these as covariates in the model. The intervention effect will be represented as the difference in amount of connected speech.

A generalized estimating equations model will be used to determine the effect of intervention group on Stroke and Aphasia Quality of Life Scale-39 (SAQOL-39)[10] scores at 12 and 26 weeks post-stroke, adjusting for known confounding variables (e.g. age, gender, NIHSS[8], mRS[9]).

Resource utilisation will be captured using a standardised approach from a societal perspective with the main focus on the health sector. This will include out-of-pocket costs to patients and family members and workforce impacts. Incremental cost-effectiveness ratios will be reported as costs per unit improvement in AQ-score and per occurrence of depression (medically diagnosed and treated and/or an ADRS score of 9 and above) avoided at 26 weeks post stroke. Societal perspective costs will include government as third party payer, costs to patients and carers/family members and limited costs to other sectors. Probabilistic multivariable analysis will be conducted to account for variability around the point estimates and results will be reported as medians (95% uncertainty intervals) using @RISK software (Palisade Corporation)[11].

Discussion

This trial is designed to test whether the intensive and prescribed VERSE intervention is effective in promoting maximum recovery and preventing costly health complications in a vulnerable population of survivors of stroke. It will also provide novel, prospective, aphasia specific cost-effectiveness data which may be used to improve resource allocation and policy development in acute and subacute hospital settings for very early aphasia intervention. Since the trial commenced recruitment, 81 patients have been enrolled from 11 hospitals.

References

1. Deloitte Access Economics. The economic impact of stroke in Australia. National Stroke Foundation. 2013.
2. Godecke E, Rai T, Ciccone N, Armstrong E, Granger A, Hankey GJ. Amount of therapy matters in very early aphasia rehabilitation after stroke: A clinical prognostic model. *Seminars in Speech and Language*. 2013;34,3:239-251.
3. Murphy TH, Corbett D. Plasticity during stroke recovery: from synapse to behaviour. *Nature Reviews Neuroscience* 2009; 10, 861-872. doi: 10.1038/nrn2735

4. Brady MC, Kelly H, Godwin J, Enderby P. Speech and language therapy for aphasia following stroke. *Cochrane Database of Systematic Reviews* 2012, Issue 5. Art. No.: CD000425.DOI: 10.1002/14651858.CD000425.pub3
5. Boutron I, Moher D, Altman DG, Schultz K, Ravaud P for the CONSORT group. Extending the CONSORT Statement to randomized trials of nonpharmacologic treatment: Explanation and elaboration. *Ann Intern Med* 2008;148:295-309
6. Kertesz A. *Western Aphasia Battery-Revised*. San Antonio: Pearson; 2006.
7. Harris A, Taylor R, Thielke R, Payne J, Gonzalez N, Conde GJ. Research electronic data capture (REDCap) – A metadata-driven methodology and workflow process for providing translational research informatics support, *J Biomed Inform.* 2009 Apr;42(2):377-81.
8. National Institute of Health Stroke Scale (NIHSS). http://www.stroke-site.org/stroke_scales/stroke_scales.html
9. Rankin J. Cerebral vascular accidents in patients over the age of 60. *Scottish Medical Journal*. 1957;2:200–215. [On-line]. Available: www.strokecenter.org
10. Hilari K. The Stroke and Aphasia Quality of Life scale 39 item version. Philadelphia: 2001.
11. @RISK software Version 5.7, 2010. Palisade Corporation, Ithaca, NY USA.
12. Enderby PM, Wood VA, Wade DT. *The Frenchay Aphasia Screening Test*. London: Whurr Publishers; 1987.
13. Ward EC, Conroy AL. Validity, reliability and responsiveness of the Royal Brisbane Hospital Outcome Measure for Swallowing. *Asia Pacific Journal of Speech, Language and Hearing*. 1999, Volume 4, Number 2: 109-129.
14. Bamford J, Sandercock P, Dennis M, Burn J, Warlow C. Classification and natural history of clinically identifiable subtypes of cerebral infarction. *Lancet*. 1991;337:1521-1526.
15. Kaplan EF, Goodglass H, Weintraub S. Boston Naming Test. *Experimental Edition*. Philadelphia: Lea & Febiger. 1983.
16. Nicholas L, Brookshire RH. A System for quantifying the informativeness and efficiency of connected speech of adults with aphasia. *Journal of Speech and Hearing*. 1993;36:338-350.
17. Benaim C, Cailly B, Pélissier J, Pérennou D. Validation of the aphasic depression rating scale. *Stroke*, 2004;35:1692.

Supplement

Competing interests

The authors declare that they have no competing interests.

Authors' Contributions

EG, EA, JB, TR, SM, AH conceived and developed the study and secured funding. EG and FE drafted the main protocol with input from all. EG and FE co-ordinate the ongoing study. TR and DC developed the statistical and economic evaluation protocols for the study, respectively. EG, EA, NC, AH, MR, AW and FE developed and drafted the VERSE intervention protocol and provided input to the grant submission. GH provided input to the protocol development, ongoing medical advice and oversees the adverse events adjudication.

Funding:

The VERSE trials is support by a National Health and Medical Research Council project grant (1044973). DC is supported by a NHMRC Public Health /National Heart Foundation Future Leader Research Fellowship (1063761).

Registration: Australasian Clinical Trials Register (Number: 12613000776707)

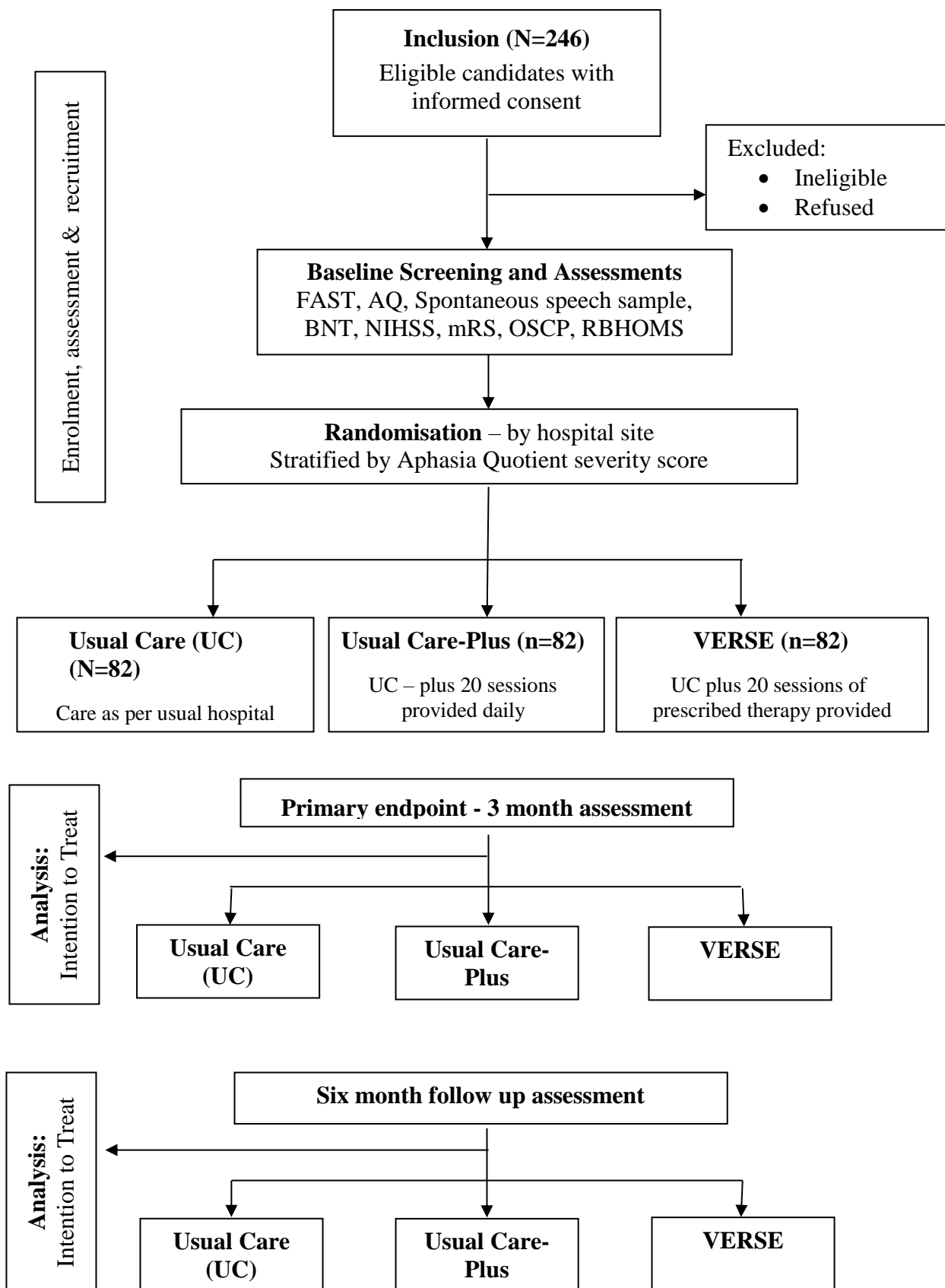


Figure 1

CONSORT Flow diagram of the VERSE trial.

Table 1. Eligibility criteria

Inclusion criteria
<p>Patients over the age of 18 with acute stroke and resultant acute aphasia of any type (ICD-10 codes 161 – 164 i.e. no TIA, SAH or SDH)</p> <p>A score of less than 93.7 of the Aphasia Quotient</p> <p>Patients who are deemed medically stable at recruitment</p> <p>Patients with the ability to maintain a wakeful alert state for 30 consecutive minutes within 14 days of stroke onset</p> <p>Patients with normal or corrected hearing and vision</p> <p>Patients with informed consent obtained by participant or person responsible</p>
Exclusion criteria
<p>Patients will be excluded from the study if they have any of the following:</p> <p>Pre existing aphasia at the time of enrolment</p> <p>Patients who have suffered a head injury, have had or require neurosurgery. (Clot retrieval surgery is not an exclusion if patient is stable post operatively and meets the above criteria)</p> <p>Pre existing clinical diagnosis of dementia</p> <p>Clinical diagnosis or treatment of major depression at time of enrolment</p> <p>Concurrent progressive neurological disorders</p> <p>Patients unable to participate in English based therapy due to English being a second language.</p> <p>Participation in other intervention trials without prior approval from VERSE trial manager.</p>

Table 2. Schedule of assessment

Assessment	Baseline	Treatment	Follow up post stroke	
	Between Day 2 and Day 14 post stroke	Day after Baseline (4-5 weeks)	Week 12 12 weeks (+/- 7 days)	Week 26 26 weeks (+/- 7 days)
Screening/Eligibility	X ¹			
Frenchay Aphasia Screening test (FAST) [12]	X ¹			
Consent	X ¹			
Western Aphasia Battery (AQ)[6]	X ²		X ⁵	X ^{5#}
Randomisation	X ¹			
Demographics	X ¹			
Past medical History	X ¹			
NIHSS[8]	X ¹			
mRS[9]	X ¹			
RBHOMB[13]	X ¹			
Oxfordshire Classification (OCSP)[14]	X ¹			
Clock Drawing/Cog test[10]	X ¹			
Boston Naming Test (BNT)[15]	X ²		X ^{5#}	X ^{5#}
Discourse collection[16]	X ²		X ^{5#}	X ^{5#}
Intervention and recording of therapy		X ³ or 4		
Stroke and Aphasia Quality of life Scale (SAQoL-39)[10]			X ^{5#}	X ^{5#}
Aphasia Depression Rating Scale [17]			X ^{5#}	X ^{5#}
Resource Utilisation			X ⁵	X ⁵
Patient diary provided		X ³ or 4**	X ⁵	
Adverse Events		X ³	X ⁵	X ⁵
Serious Adverse Events		X ³	X ⁵	X ⁵

X¹ = person screening and enrolling the subject. May be X²

X² = Trained speech pathologist

X³ = Usual care speech pathologist (UC and UC Plus)

X⁴ = VERSE therapist

X⁵ = Blinded Assessor

** Diary provided on last day of therapy with treating speech pathologist. This may be on discharge from the acute ward or as late as Day 50.

Secondary outcome measure

