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THE MAIN APPROACHES TO THE TREATMENT OF PAIN SYNDROME IN THE SHOULDER JOINT AFTER A STROKE AT THE OUTPATIENT STAGE REHABILITATION

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Numerous methods of pain syndrome treatment focus mainly on normalization of muscle tone, reduction of shoulder joint subluxation or treatment of suspected inflammation of the shoulder capsule or surrounding tissues [2, 3]. Nevertheless, the results of treatment are often unsatisfactory, and the pain syndrome persists in patients for a long time.

The aim of the study is to evaluate the effectiveness of the use of mirror therapy, kinesotaping and physical therapy in the complex treatment of patients with post-stroke pain syndrome.

Material and methods. The study involved 95 patients (68 men and 27 women) who were treated in the rehabilitation department of the ASMI clinic. The criterion for inclusion in the study was the presence of pain in the shoulder joint area, limiting the volume of both active and passive movements. All persons suffered an ischemic stroke, the duration of the disease was 2-4 months.

The main group of the examined patients consisted of 70 patients who were treated with the complex of treatment proposed by us (kinesotaping of the shoulder joint and shoulder, mirror therapy and physical therapy), 25 patients engaged in the generally accepted method of restorative treatment (physical therapy, orthosis, magnetic therapy, thermal therapy, massage), made up the control group. The course of rehabilitation treatment averaged 14 days.

The design of the study included a neurological examination, an assessment of the severity of pain on a 10-point visual analog scale (VAS) and the assessment of the function of the shoulder joint according to a specialized index scale [4], the assessment of the functional activity of the hand was carried out according to the Frenchay Arm Test, which were performed before and after treatment.

Results. By the time of the start of treatment, all patients had pain in the shoulder joint, which was a serious obstacle to the restoration of impaired movements and functions of the arm. According to the VAS scale, the severity of pain syndrome before treatment in the main group was 8.8 points, in the control group 8.3 points.

The average clinical index calculated on the basis of the evaluation scale was 2.0 in both groups, which corresponded to a pronounced violation of the function of the shoulder joint, the functional activity of the hand, according to the Frenchay test, was estimated at 0-1 points.

The results of treatment of post-stroke pain syndrome with PIBS on the VAS scale showed positive clinical dynamics in the main group of 2.3 and with 3.5 points in the control group.

Positive changes against the background of treatment in the main group according to the scale of assessment of the function of the shoulder joint, the average clinical index

reached 2.7 ($p < 0.001$), in the control group — 2.2 ($p < 0.05$).

The functional activity of the hand, according to the Frenchay test, in the main group increased to 4-5 points, in the control group to 2-3 points.

Conclusion. Comprehensive rehabilitation of patients with PIBS, including the use of kinesotaping of the shoulder joint and shoulder, mirror therapy and physical therapy allowed to reduce the severity of pain syndrome, improve the functional activity of the upper limb, increase the volume of movements in the shoulder and generally increase the rehabilitation potential of patients. The method is well tolerated and can be recommended for wide use in outpatient settings.

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