Specific Question: In adult patients immediately post primary total knee replacement (TKR) for osteoarthritis (OA) is group therapy more clinically effective than an individual programme for pain and function?

Clinical bottom line
After TKR, group rehabilitation is not more effective than individual rehabilitation. Individual rehabilitation appears similarly effective if undertaken as a package of 2 initial individual face-to-face treatment sessions followed by telephone support for a home exercise programme or as a package of 12 individual treatment sessions.

Why is this important?
Post TKR rehabilitation is delivered in a variety of ways across Shropshire including individual one-to-one treatment sessions and group sessions. Is there a form that is the most clinically effective?

Inclusion Criteria
Adults following primary TKA for OA, where rehabilitation is delivered in either a group setting or on a one-to-one basis.

Search (2000-2015)
Cochrane systematic reviews
Medline
CINAHL
PEDRo
NHS Evidence

Type of Study
systematic reviews & RCT’s
<table>
<thead>
<tr>
<th>Description</th>
<th>Search terms</th>
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<tbody>
<tr>
<td><strong>Population and Setting</strong></td>
<td>male and female adults immediately post primary TKR for OA</td>
</tr>
<tr>
<td><strong>Intervention or Exposure (ie what is being tested)</strong></td>
<td>group therapy / rehabilitation / exercise classes / physiotherapy / physical therapy</td>
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<td><strong>Comparison, if any</strong></td>
<td>individual programme of physiotherapy / physical therapy/ one to one exercise / rehabilitation /physiotherapy / physical therapy</td>
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<td><strong>Outcomes of interest</strong></td>
<td>reduced pain, increased function, patient satisfaction</td>
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<tr>
<td><strong>Types of studies</strong></td>
<td>systematic reviews &amp; RCT’s</td>
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</table>

**Routine Databases Searched**


Date of search
02/01/2015
## Results

<table>
<thead>
<tr>
<th>First Author, year and type of study</th>
<th>Population and setting</th>
<th>Intervention or exposure tested</th>
<th>Study results</th>
<th>Assessment of quality and comments</th>
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<tbody>
<tr>
<td>Ko 2013 RCT</td>
<td>Adults following primary TKR for OA</td>
<td>249 patients were randomized into three groups. One-to-one therapy: 12 sessions over 6 weeks of manual therapy, therapeutic modalities (e.g. cryotherapy) and specific exercises. Group therapy: 12 sessions over 6 weeks of a 50 minute circuit of weight bearing functional tasks (e.g. stairs), specific exercises (e.g. step-ups) and aerobic activities (e.g. stationary cycling). Monitored home programme: 2 individual sessions on instruction and progression of a home based exercise programme similar in content to the group therapy programme with telephone follow-ups.</td>
<td>Primary outcome: knee pain &amp; function measured by the Oxford knee score No significant difference in any outcomes were found between the groups.</td>
<td>Assessed as a high quality study with the use of the CASP RCT tool.</td>
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### Summary

Of the papers identified from the search only one RCT was highlighted as potentially being able to answer the question (Ko et al 2013).

There is evidence to suggest that group therapy is not clinically more effective than an individual programme at improving pain and function. The individual programme would appear to be equally effective delivered either through 2 initial face-to-face individual sessions with telephone support for a home exercise programme or a 12 session programme of individualised manual therapy, specific exercises and therapeutic modalities.

The implications of this for practice suggest our current practice improves outcomes for pain and function but it does suggest we review the delivery of rehabilitation to ensure cost effectiveness as well as clinical.
References