Huntington’s disease
European Huntington’s Disease Network Physiotherapy Working Group
Clinical Implementation Strategy

People with Huntington’s disease (HD) demonstrate a range of physical, cognitive, psychological and social care needs over an extended timeframe. One of the difficulties in developing clinical guidelines for complex neurodegenerative diseases such as HD is the heterogeneity of clinical signs and symptoms. Whilst staging of the disease process (e.g. early, middle, late) can provide a general framework for intervention, within each stage there is a wide range of potential impairments that can impact an individual’s level of functional activity and life participation. This makes structuring of consistent therapeutic approaches problematic. This problem is not unique to HD, and has been documented in other physiotherapy patient groups, most notably low back and neck dysfunction, and for general neurorehabilitation patient groups [1-3].

Clinical guidelines are evidenced-based recommendations for clinical practice in specific conditions [4, 5]. The availability of clinical guidelines facilitates uniformity of care and standards of practice with the aim of improving quality of care provision. It is critically important for health professionals to be able to define and document their assessment and intervention strategies. The application of appropriate guidelines in practice, as well as systematic outcome evaluation, has the potential to promote evidenced-based delivery of care for the benefit of the person with HD.

Members of the European Huntington’s Disease Network (EHDN) Physiotherapy Working Group (PWG) are advocating a treatment-based classification approach to specifically guide intervention strategies in HD. Utilisation of treatment-based classifications may help to address the heterogeneity of impairments and activity limitations seen in people with HD, and provide a structure for standardised data collection of interventions and outcomes. It is hoped that by creating sub classifications of patients’ impairments and problems, and matching those with more specific interventions, therapists may improve outcomes in their patients. The following seven classifications have been developed to better categorize patients with HD, who can present with a wide array of functional problems and physical, cognitive and behavioural impairments. It is the aim of the PWG that these treatment-based classifications will subsequently inform evaluation of complex interventions and advance research into care and evidenced-based service delivery for people with HD. As the complex nature of HD makes it unlikely that any one professional will have all the skills needed for best practice, these classifications have also incorporated referral to relevant members of the multi-disciplinary team.

Therapists should review the signs and symptoms of each classification to determine the best fit for a particular patient. Once a classification has been determined, therapists should use it as a guide to selecting appropriate evaluation measures and intervention strategies. Importantly, these classifications are not designed to take the place of independent clinical decision-making based on each patient’s particular signs and symptoms, but rather should provide a framework for more consistent patient management through the disease spectrum.

<table>
<thead>
<tr>
<th>Classification</th>
<th>Description</th>
<th>Stages</th>
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<tbody>
<tr>
<td>A. Exercise Capacity and Performance</td>
<td>Absence of motor impairment or specific limitations in functional activities; potential for cognitive and/or behavioural issue</td>
<td>Pre-manifest/early</td>
</tr>
<tr>
<td>B. Planning and sequencing of tasks</td>
<td>Presence of apraxia or impaired motor planning; slowness of movement and/or altered force generation capacity resulting in difficulty and slowness in performing functional activities.</td>
<td>Early-mid</td>
</tr>
<tr>
<td>C. Mobility, Balance and Falls Risk</td>
<td>Ambulatory for community and/or household distances; impairments in balance, strength or fatigue resulting in mobility limitations and increased falls risk.</td>
<td>Early-mid</td>
</tr>
<tr>
<td>D. Secondary adaptive changes and deconditioning</td>
<td>Musculoskeletal and/or respiratory changes resulting in physical deconditioning, and subsequent decreased participation in daily living activities, or social work environments.</td>
<td>Early-mid</td>
</tr>
<tr>
<td>E. Impaired postural control and alignment in sitting</td>
<td>Improper alignment due to adaptive changes, involuntary movement, muscle weakness and incoordination resulting in limitations in functional activities in sitting.</td>
<td>Mid-late</td>
</tr>
<tr>
<td>F. Respiratory dysfunction</td>
<td>Impaired respiratory function and capacity; limited endurance; impaired airway clearance resulting in restrictions in functional activities and risk for infection</td>
<td>Mid-late</td>
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<tr>
<td>G. End Stage Care</td>
<td>Active and passive range of motion limitations and poor active movement control resulting in inability to ambulate; dependent for most ADLs; difficulty maintaining upright sitting position</td>
<td>Late</td>
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</table>
# A. EXERCISE CAPACITY AND PERFORMANCE

## Signs and symptoms / key issues and potential issues

<table>
<thead>
<tr>
<th>Participation</th>
<th>Activities</th>
<th>Impairments</th>
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<tr>
<td>possible quality of life changes</td>
<td>no problems</td>
<td>Potential for: early gait changes, poor endurance or fitness; mild chorea; cognitive and/or behavioural issues; poor endurance and limited physical activity; lack of motivation and/or apathy; anxiety and/or depression [6, 7]; sleep disturbance which may exacerbate the above impairments</td>
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</table>

## General aims

- Facilitate health education and advice - this includes general health promotion strategies, referral for exercise on a prescriptive plan, and agenda setting to optimise exercise performance.
- Patient & family education – focus on importance of early intervention in HD. In animal models of HD, early enrichment of the environment (i.e., exercise) was shown to delay symptom onset and severity [8]. Increased physical activity in HD mice was critical for successful outcomes of disease modifying treatments such as cell transplants and reconnection of grafted tissue. [9].
- Facilitate active lifestyle – this is thought to delay the disease onset in people with HD [10] and to reduce the risk of other neurodegenerative disease such as Alzheimer’s disease [11] and Parkinson’s disease [12]. In addition, participation in regular exercise has potential to result in improved strength, cardiovascular fitness, exercise tolerance, functionality, mobility and mood.

## Treatment options

- Baseline testing for fitness level should be completed prior to exercise prescription. Consider education on fatigue and the timing of intervention/exercises during the day as well as careful instruction on safety during exercise.
- Identify barriers and facilitators to initiate and maintain an exercise programme [13]. Techniques such as behavioural motivation can be used to help patient identify barriers and facilitators and explore strategies to manage them [14]. Involvement of a caregiver/friend/spouse can make the programme more successful.
- Gym based exercises can be of benefit to physically-able individuals, as well as people with long term neurologic conditions such as Parkinson’s Disease [15]. Small case reports in HD [16, 17] indicate that if properly supported, people with HD can enjoy the health benefits of physical activity. Interestingly, there is underutilization of PT services in early-stage HD [18]. Exercise in early stage HD should include:
  - Individualized goal setting and home exercise programme prescription for optimization of services in a life-long disease process.
  - A focus on task-specific functional activities incorporated into the exercise programme.
  - A warm-up and cool-down.
  - Careful monitoring of vital signs, dyspnoea, fatigue, pallor, dizziness and specific HD-related signs at rest, during and after exercise.
- Frequency, intensity, duration and mode are dependent on the baseline fitness level of the individual; however, focus should be on the ACSM goal of exercise for both aerobic and strength training. [19].

## Aerobic exercise:

- Frequency: 3 to 5 times a week; Intensity: 65% to 85% of the maximal heart rate; 55% to 65% of maximal heart rate for de-conditioned individuals; Duration: at least 30 minutes of continuous or intermittent training per day (minimum of 10-minute bouts accumulated throughout the day); Mode: any activity that the individual enjoys that uses large muscle groups which can be maintained continuously and is rhythmic and aerobic in nature (e.g. walking, jogging, swimming, and biking).

## Resistance exercises:

- Frequency & Duration: 8 to 12 repetitions per exercise; One set of 8 to 10 exercises that conditions large muscle groups 2 to 3 times a week; Intensity: 65% to 70% of 1 rep max for upper body and 75% to 80% of 1 rep max for lower body parts; Mode: Resistance training should be progressive and individualized.

## Exercise programme ideas:

- Walking (treadmill and over-ground), stationary bicycling, horseback riding, strength-training, balance training, core stability training, video-game based exercise (Nintendo Wii, Dance Dance Revolution) [20]. Yoga, pilates, tai chi and relaxation are also recommended.
B. PLANNING AND SEQUENCING OF TASKS

<table>
<thead>
<tr>
<th>Signs and symptoms / key issues and potential issues</th>
<th>General aims</th>
<th>Treatment options</th>
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</thead>
<tbody>
<tr>
<td>Participation: Patients may note a decline in independence in their daily routine, and may experience difficulty managing previously automatic tasks such as rising from a chair or walking.</td>
<td>Creation of individualized patient-centred goals that focus on the specific impairments of the patient.</td>
<td>Task-specific training to address planning and sequencing deficits.</td>
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<tr>
<td>Activities: Difficulty and slowness in performing functional activities (dressing, bathing, stair climbing, indoor/outdoor ambulation, ADLs)</td>
<td></td>
<td>Could include:</td>
</tr>
<tr>
<td>Impairments:</td>
<td>• Improve ability to perform functional tasks</td>
<td>• strategy training in daily living activities: this technique teaches internal (for example, the patient is taught to verbalise and implement the task steps at the same time) or external (for example, when aids are used to overcome a functional barrier) compensatory strategies that enable a functional task to be completed [32]; spaced retrieval and errorless learning techniques can guide training of motor activities and learning of skilful activities [33].</td>
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<tr>
<td>• Apraxia – impaired motor planning [31]</td>
<td>• Increase speed of movement</td>
<td>• sensory stimulation: deep pressure and soft touch are applied to the patients' limbs; therapies utilizing a multi-sensory stimulation approach noted significant improvements in mood and stimulation which were cumulative over sessions when compared to the control group [34].</td>
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<tr>
<td>• Movement speed – slowed speed of movement during purposeful task</td>
<td>• Maximize safety</td>
<td>• cueing: visual, verbal or physical prompts: enable task completion. Verbal prompts can include attentional strategies with external cues and/or, attentional strategies with internal cues</td>
</tr>
<tr>
<td>• Force generation – generalized and/or specific muscle weakness; delayed onset of muscle response</td>
<td></td>
<td>• chaining (forward or backward): the task is broken down into its component parts. Using backward chaining the task is completed with facilitation from the therapist apart from the final component, which the patient carries out unaided. If successful, further steps are introduced in subsequent trials.</td>
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<tr>
<td>• Safety awareness and insight into deficits</td>
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Outcomes Measures:
SF-36: A quickly and easily administered Quality of Life measure commonly used in HD; robust construct validity and test-retest reliability have been demonstrated [35].
10 Meter Walk: used as a measure of gait speed [36].
Physical Performance Test (PPT): useful for measuring ability to perform everyday tasks including utensil use, writing, donning/doffing a jacket, walking and stair climbing.
Goal Attainment Scale: See A: Exercise Capacity and Performance for description.
Timed Up & Go: [37] The participant is instructed to stand from a chair, walk 10 feet, return to the chair and be seated. Times greater than 13.5 seconds accurately predicted elderly falls with 90% accuracy. The TUG has been validated in HD [26, 37].
• TUG Manual complete TUG while carrying a full cup of water; a time difference of >4.5 seconds between TUG and TUG Manual indicated increased risk of future falls in elderly
• TUG Cognitive [38] (Gait speed, dual-task ability); complete the TUG while counting backwards from a randomly selected number between 20 and 100.

Four Square Step Test (4SST): participants step forward, sideways and backward over low obstacles (usually canes) in a sequence; a useful measure of balance, stepping ability and motor planning [39].

The Apraxia Test: consists of two subtests assessing the ability to use objects or pantomime use and the ability to imitate gestures [40].

Timed Sit-to-Stand Test: patients are asked to stand up and sit back down 5 times from a chair that reaches the head of their fibula. Time to complete 5 repetitions are recorded. The Sit-to-Stand test is commonly used to assess leg strength and balance and has been shown to be a reliable and valid measure in older adults and other patient populations [41].

Interdisciplinary:
Speech and Language Therapy: assessment and management of communication (dysarthria and apraxia of speech; influence of cognitive ability in particular difficulties in executive functioning and in working memory on linguistics, speech and communication skills); assessment and management of swallowing and dysphagia and any association with motor function/ planning problems.
C. MOBILITY, BALANCE AND FALLS RISK

Signs and symptoms / key issues and potential issues

Participation:
- Fear of falling may result in more unwillingness to participate in home, work, and community activities
- Difficulty in participating in recreational sports (e.g., cycling, running, soccer, basketball) that require balance and mobility

Activities:
- Difficulty walking in certain environments (i.e., open environments)
- Difficulty walking backwards or side-wards
- Difficulty turning and changing directions
- Difficulty getting in and out of chairs and beds due to vauling, poor eccentric control
- Difficulty with walking while doing a secondary cognitive or motor task due to attentional deficits [43]
- High falls risk [26, 44]

Impairments:
- Bradykinesia [45]
- Dystonia – affecting trunk (lateral shift; extension), ankles/feet (inversion) [46]
- Chorea*/rigidity [47-49]
- Muscle weakness or impaired force production [50]
- Impaired motor control (i.e., force modulation deficits causing sudden exaggerated movement changes; impaired eccentric motor control)
- Decreased limb coordination resulting in step asymmetry
- Fatigue and its associated influence on physical performance may lead to falls
- Balance deficits (increased sway in stance and during functional tasks of daily living, delayed responses to perturbations, difficulty with tandem standing and walking) [16, 51, 52]
- Gait impairments (decreased speed; stride length; stride width, increased variability in gait parameters)[53, 54]
- Cognitive and behavioural issues including not recognizing their own disabilities and doing unsafe behaviours due to impulsiveness, attentional deficits and problems with dual tasking [44, 55, 56]
- Deficits in spatial perception causing people with HD to run into walls or tables [57]
- Visual disturbances such as difficulty with saccadic eye movements and smooth pursuit can impact balance and walking [58]

General aims

- Improve mobility status (increase independence; increase speed; increase distance walked)
- Reduce risk of falls or actual falls**
- Maintain independent mobility including transfers and walking for as long as possible
- Reduce fear of falling which in itself may cause inactivity

Outcome Measures:
- SF 36 : see B
- Function Assessment section of the UHDRS : which consists of the Functional Capacity Scale, the Independence Scale, and a checklist of common daily tasks for assessment of basic ADLs and IADLs. The total score on the Functional Capacity Scale is reported as the total functional capacity (FtC) score. The Independence Scale is rated from 0 to 100. Higher scores indicate better functioning [60]
- HD-ADL : an informant rated instrument designed to follow disease progress. An ADL total score is calculated by summing all of the values for the five domains of Personal Care, Home Care, Work and Money, Social Relationships, and Communication. Validity and reliability has been demonstrated for subjects with HD on the seventeen items of adaptive functioning. Scores range from 0 (Independent) to 24 (Maximum disability) [60]

TUG : see B

Measures:
- Berg Balance Scale :
- ABC scale :
- Tinetti Mobility and Gait Test :

Falls history
- UHORI motor section [65]
- Assessments of different devices and equipment used during functional activities including the safety during use, alignment, fit, and the patient’s ability to care for the devices or equipment

Interdisciplinary : interdisciplinary : nursing, OT, neuropsychologist, neurologist
- see Management of chorea
- **See Policy on Falls and Mobility, EHON Physiotherapy Working Group

Treatment options

- Impairment exercises : strengthening; general conditioning; endurance; range of motion activity to counteract effects of dystonia; coordination exercises; teach strategies to help people with HD identify when fatigue would increase their risk of falls [58, 59]
- Balance training to practice the maintenance of postural control in a variety of tasks and environments
  - Train patients to step in response to perturbations in all directions with speed and accuracy
  - Practice activities that require automatic responses (e.g., throwing ball) to elicit postural responses and train faster movements
  - Progress activities from wide to narrow BOS , static to dynamic activities, low to high COG , increasing degrees of freedom
  - Task-specific practice of functional activities such as transfers, reaching high and low, stair climbing, etc. to train balance control during activities of daily living
  - Task specific training to address walking tasks, ideally in specific environments (e.g. outdoor, obstacles) ; external cueing [16, 59, 60]
  - Train patients to walk forwards, backwards, and sideways at different speeds and over different surfaces
  - Use metronome [55, 61, 62], lines on floor to promote step initiation, bigger steps, faster speed, and gait symmetry
  - Teach strategies as to how to get up from floor if they fall
  - Teach safety awareness and adaptation of environment (reduce clutter, slippery surfaces, loose rugs, poor lighting, sharp or breakable objects), furniture
  - Provision of assistive devices (4 wheeled walker with brakes) when appropriate; if patient is unsafe with assistive devices, human support such as holding the person’s arm may be helpful [63]
  - Family/carer education for guarding and/or assistance during ambulation

Adaptive devices/equipment
- Wheelchair prescription (long distance mobility)
- Shoe/orthotic evaluation (shoes with ankle support such as high top tennis shoes or boots; heel wedge and/or lateral wedge for ankle dystonia in inversion/eversion direction; ankle foot orthosis for ankle dystonia in dorsiflexion/plantarflexion direction; custom made shoe inlay for individuals with clawing of toes during walking)
- Prescribe protective gear – helmets, elbow/knee pads to be worn by person with HD at risk for falls
- Teach compensatory strategies for cognitive impairments and inability to dual task
  - Teach patients to focus their attention on maintaining balance before doing a task that challenges their balance [64]
- Have people with HD practice two activities at same time under various practice and context conditions in early stages [55, 56]
- Teach patients to break down complex tasks into simpler tasks and attend to one task at a time in middle to late stages
D. SECONDARY AND ADAPTIVE CHANGES AND DECONDITIONING

**Signs and symptoms / key issues and potential issues**

**Participation:**
- Decreased level of physical fitness
- Decreased participation in ADLs, social or work environments

**Activities:**
- Decreased daily walking and physical activity levels in people with HD compared to healthy individuals [24]
- Daily walking levels significantly more reduced in people with HD who were recurrent fallers compared to those who were non-fallers [26].

**Impairments:**
- Musculoskeletal changes - loss of ROM, loss of strength due to inactivity [50]
- Respiratory changes – reduced endurance
- Cognitive problems such as memory deficits, loss of initiative or insight into problems [43]
- Psychological issues such as depression, apathy, anxiety
- Weight loss due to multiple factors may contribute to weakness, fatigue [73]
- Pain caused by dystonia, muscle imbalances, trauma from falls or hitting objects, immobility [74]
- Balance and gait impairments resulting in frequent falls (see Mobility, Balance, and Falls Risk)

**General aims**
- Prevent further physical, cognitive, and psychological deterioration
- Improve strength, balance strategies, and stamina
- Motivate patients to regain some control of their lives by adopting a healthy lifestyle
- Increase patient and caregiver awareness of benefits of regular exercise and detrimental effects of inactivity
- Weight control
- Pain management

**Treatment options**
- Educate patient and caregivers on benefits of exercise for people with HD and negative consequences of inactivity
- Initiate maintenance programme to prevent secondary adaptive changes and deconditioning [75, 76]
- Encourage person with HD to start/restart exercise programme and provide exercise log or diary to record progress
- Consider formal or informal programmes: individualized or group exercise programmes in community/hospital settings [60]; exercise video or written instructions with pictures to increase home exercise compliance
- Assess for appropriate walking aids, devices (e.g. assistive, adaptive, orthotic)
- Treat balance and gait impairments, fear of falling that may underlie activity limitations [77]
- Educate caregivers on strategies to motivate (incorporate exercise into daily routine, positive reinforcement, participate in exercise with the patient, select physical activities that the patient enjoys) and assist their loved ones (i.e., cueing, guarding, use of gait belt) with exercise programmes [78]
- Encourage patients to seek out enriched environments that are physically and cognitively stimulating and promote social interactions
- Teach breathing exercises to maintain full respiratory function
- Educate patient on importance of proper nutrition and maintenance of adequate weight
- Manage pain appropriately with modalities [79], ROM exercises, proper positioning, protection from injuries, medications, etc.

**Outcome Measures:**
- SF-36 (see A)
- Berg Balance Scale (see C)
- 6MWT (see A)

**Impairment measures:**
- Aerobic capacity during functional activities, or during standardized exercise test (early stages); Cardiovascular and pulmonary signs and symptoms in response to exercise or increased activity; Weight measurements; Mini Mental State Examination (MMSE)(90);
- manual muscle testing or hand held dynamometry for muscle strength; Pain numerical rating scale, Pain Visual Analog scale (VAS), Wong-Baker FACES pain rating scale [74]; UHDRS Behavioral assessment section [65]; Goniometry, and feel assessment, and multisegment flexibility tests for ROM assessment; Respiratory rate, rhythm, and pattern, auscultation of breath sounds, cough effectiveness testing, vital capacity (VC) testing in supine and upright positions or forced vital capacity (FVC) testing for respiratory assessment

**Interdisciplinary:**
- nutritionist, OT, psychologist, personal trainers
### E. IMPAIRED POSTURAL CONTROL AND ALIGNMENT IN SITTING

<table>
<thead>
<tr>
<th>Signs and symptoms / key issues and potential issues</th>
<th>General aims</th>
<th>Treatment options</th>
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</thead>
<tbody>
<tr>
<td><strong>Participation:</strong></td>
<td>• Prevent or limit soft tissue adaptive changes</td>
<td>• Manual handling and falls risk assessment review</td>
</tr>
<tr>
<td>• Increased caregiver burden</td>
<td>• Minimize risk of infection and skin breakdown</td>
<td>• Institute positioning schedule for patients with limited active movement</td>
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<tr>
<td>• Withdrawal from society</td>
<td>• Maximize independence in sitting and facilitate appropriate positioning</td>
<td>• Musculoskeletal realignment and facilitation of more efficient patterns of movement [81].</td>
</tr>
<tr>
<td><strong>Activities:</strong></td>
<td>• Maximize functional ability – eating, reaching tasks, dressing, self positioning, transfers</td>
<td>Options include:</td>
</tr>
<tr>
<td>• Difficulty with ADLs including washing, dressing</td>
<td></td>
<td>• Stretches where appropriate</td>
</tr>
<tr>
<td>• Difficulty with feeding and swallowing</td>
<td></td>
<td>• Active and passive range of motion exercises</td>
</tr>
<tr>
<td>• Inability to stand or sit independently</td>
<td></td>
<td>• Positioning (24 hours consideration)</td>
</tr>
<tr>
<td><strong>Impairments:</strong></td>
<td></td>
<td>• Splinting</td>
</tr>
<tr>
<td>• Inappropriate musculoskeletal alignment</td>
<td></td>
<td>• Strengthening</td>
</tr>
<tr>
<td>• Decreased range of movement (active and passive)</td>
<td></td>
<td>• Specific trunk stability exercises</td>
</tr>
<tr>
<td>• Soft tissue adaptive changes</td>
<td></td>
<td>• Assess suitability of seating; wheelchair evaluation</td>
</tr>
<tr>
<td>• Altered base of support leading to:</td>
<td></td>
<td>• Respiratory assessment as appropriate [82]</td>
</tr>
<tr>
<td>• Changes in dystonia/ chorea</td>
<td></td>
<td>• Educate carers and patient re: risk of aspiration</td>
</tr>
<tr>
<td>• Poor balance</td>
<td></td>
<td>• Alignment in each posture [81]</td>
</tr>
<tr>
<td>• In-coordinated movement</td>
<td></td>
<td></td>
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<tr>
<td>• Pressure areas due to shearing</td>
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<tr>
<td>• Potential for falls and soft tissue damage</td>
<td></td>
<td></td>
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<tr>
<td>• Risk of aspiration and respiratory complications</td>
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</tbody>
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**Description:** Improper alignment due to adaptive changes, involuntary movement, muscle weakness and incoordination resulting in limitations in functional activities in sitting. **Stage:** mid/late

**Outcome Measures:**

- **Caregiver Burden Scale:** Used to assess burden of care among caregivers. It is a 29-item scale designed to measure feelings of burden experienced by caregivers of elderly persons with senile dementia [83].
- **Goal Attainment Scale (see A):** decreased dependence in ADL, time tolerated in chair

**Interdisciplinary:**

Nursing, SALT for swallow assessment, Respiratory physiotherapist, OT, Liaise with specialist OT re: seating and hoist equipment
### F. RESPIRATORY DYSFUNCTION

**Signs and symptoms / key issues and potential issues**

<table>
<thead>
<tr>
<th>Participation</th>
<th>General aims</th>
<th>Treatment options</th>
</tr>
</thead>
</table>
| Participation in social activities e.g. shopping, family activities Participation in exercise activities | • optimize respiratory function for functional activities  
• optimise cardiorespiratory function  
• maintain PCF ≥ 270 L/min when well; PCF ≥160 L/min when unwell with cold/respiratory infection [84]  
• optimize secretion clearance | • functional exercise  
• positioning to manage breathlessness [85]  
• breathing exercises; maximal insufflation/exsufflation; glossopharyngeal breathing[84, 86]  
• airway clearance techniques [87]  
• postural management [88]  
• relaxation  
• consultation for appropriate walking aids e.g. wheeled walker/rollator  
• cardiovascular exercise training [86] |
| Activities: Decreased exercise tolerance; limited ability to perform ADLs, ambulation | Impairments:  
• breathlessness on exertion or at rest  
• decreased exercise capacity  
• ineffective cough  
• retained secretions  
• increased work of breathing  
• cyanosis  
• decreased oxygen saturation  
• dystonia of trunk muscles | Outcome Measures:  
Borg breathlessness/MRC scale breathlessness scale (Australian Lung Foundation)  
6MWT: (see A)  
Peak cough flow (PCF) [84]  
Auscultation/observation/saturation monitor  
Forced Vital Capacity | Interdisciplinary:  
SALT [89], nursing, respiratory therapist, pulmonologist |
PHYSIOTHERAPY CLINICAL GUIDELINES FOR HUNTINGTON’S DISEASE

G. END STAGE CARE

Description: active and passive range of motion limitations and poor active movement control resulting in inability to ambulate; dependent for most ADLs; difficulty maintaining upright sitting position

Stage: Late

Signs and symptoms / key issues and potential issues

Participation: complete dependence in functional skills; social isolation

Activities:
Unable to ambulate; dependent for most ADLs; difficulty maintaining upright sitting position

Impairments:
- limited volitional control of limbs and trunk
- chorea and/or rigidity
- limitations in passive range of motion
- risk for aspiration/respiratory infection
- risk for pressure sores; pain due to positioning or pressure sores or contractures
- difficulties or inability to communicate
- depressed mood or depression
- pain

General aims

- Minimize risk of aspiration/respiratory infection
- Minimize risk of bed sores
- Promote ability to maintain upright sitting position
- Promote optimal comfort in bed
- Maintain/increase range of motion
- Maintain existing ADLs
- Support and brief nursing staff or caregivers
- If necessary: provide support to organize external help (home-nursing services) or relocation to a specialized institution

Treatment options

Positioning [75]
- In bed – utilize pressure relieving mattresses and cushions for optimal positioning; utilize positioning schedule in bed to promote position change (side-lying and supine)
- Upright – consultation for appropriate supportive chair. Key features include padded supports (to prevent injury secondary to involuntary movements), tilt in space to maintain appropriate hip angle and allow for change in position for pressure relief; adequate trunk and head supports; adequate padded foot supports
- Close cooperation with nursing staff / caregiver to improve transfers, eating position, communication, washing and dressing and to preserve whatever independence the patient has in terms of ADL’s. Advise as to signs of aspiration.

Range of motion [75] - create range of motion exercise plan to be performed daily by nursing staff, aides, or family members. Regular physiotherapy sessions advisable.

Active movement [75] – if able, encourage upright standing with support (consider use of standing table); sitting on edge of bed (with support); active exercises in bed to prevent muscle wasting and prevent breakdown; work with existing capabilities to maintain current ADLs

Respiratory (see Respiratory TC)

Outcomes Measures:
- Braden Risk Assessment Scale: grading tool for risk of pressure ulcers [90]
- National Pressure Ulcer Advisory Panel (NPUAP) - pressure ulcer staging [91]; respiratory function assessment; ability to sit upright in adaptive chair for measured period of time; LE/UE range of motion assessment using goniometer; pain assessment with FACES pain scale [74]; Caregiver Burden Scale [83] if patient remains at home

Interdisciplinary:
- Nursing, respiratory therapy, SALT, clergy for spiritual support, psychologists for grief counseling, OT for seating, social workers for living wills, power of attorney
References


14. vanNmewen M, Speelman AD, Smidtens K et al. Design and baseline characteristics of the ParkFit study, a randomized controlled trial evaluating the effectiveness of a physiotherapy program to increase physical activity in Parkinson patients. BMC Neurol 15, 70 (2015).


Huntington’s disease

European Huntington’s Disease Network Physiotherapy Working Group*