

# Management of Medical Rehabilitation in Stroke Infarction Patients at Type C Hospitals: Case Report

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## ABSTRACT

Stroke rehabilitation is the comprehensive medical management and rehabilitation of disabilities caused by stroke using a neurorehabilitation approach with the aim of optimizing recovery and/or modifying the remaining symptoms so that the stroke survivor can independently perform functional activity, adapt to the environment, and live a quality life. We present a case of medical rehabilitation for an infarct-related stroke with hypocalcemia, hypertension, and Type II diabetes. In this case, treatment at a hospital of type C is limited to initial treatment and medical rehabilitation; the acute and subacute phases, which provide modifications to previous MMT and ADL dependence, are less intensive. Early evaluation and treatment are crucial for optimizing rehabilitation.

**Keywords:** medical rehabilitation; stroke infarction; type c hospitals

## INTRODUCTION

Stroke rehabilitation is a comprehensive medical management and rehabilitation of disabilities caused by stroke through a neurorehabilitation approach with the goal of optimizing recovery and/or modifying the remaining symptoms so that the stroke survivor can independently perform functional activity, adapt to the environment, and live a quality life [1]. Forty percent of stroke patients are left with moderate functional impairments, while 15 to 30 percent are severely disabled [2]. Disability is a significant national issue. WHO estimates that between 7 and 10 percent of the world's population is disabled [3]. Obviously, this quantity is extremely concerning. According to the findings of the study Seamic Health Statistic (Int mint found japan1998), between 1991 and 1995, stroke became the leading cause of mortality in Indonesia and the leading cause of disability among adults [4]. In Indonesia, the incidence of stroke is increasing. With the expanding administration of science and technology in health, extensive vaginal survival has increased, despite the presence of severe residual symptoms [5]. As a result of ill dietary habits, a stressful lifestyle, and the absence of a sports culture due to a lack of time, the prevalence of strokes in the productive age shifts [6].

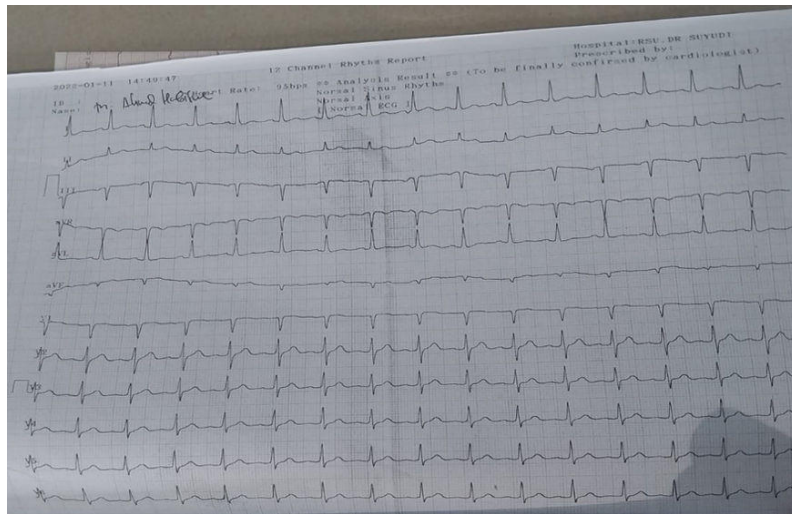
The purpose of this case study is to examine the Management of Medical Rehabilitation for Stroke Infarction Patients in Type C Hospitals.

## CASE REPORT

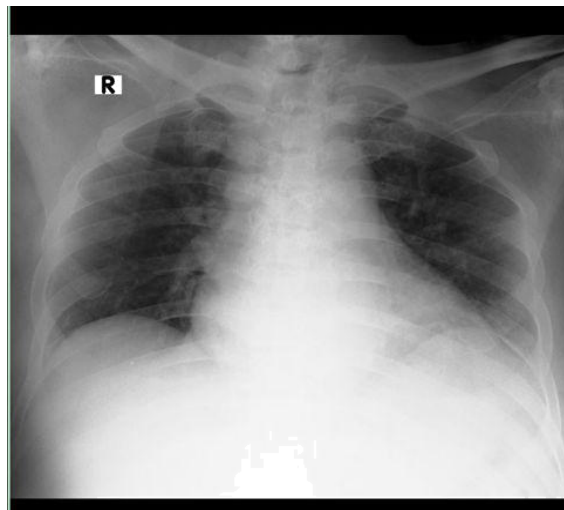
Patient Mr. AH, 53 years come to emergency departments of Dr Suyudi hospitals by complaint the weakness of the left motion members in the past 3 days before entering the hospital, the patient is often headaches come and go since the last 1 month, nausea (-), vomiting (-), seizures (-), fever (-). The history of DM and HT disease does not take drugs regularly.

On physical examination, we found TD: 160/100 mmHg, HR: 88x irregular, RR: 22x. T: 36,9 C, and SpO<sub>2</sub>: 98%. Laboratory results showed hipopotassium (3.41), increased liver function with SGOT (57) and SGPT (94), and Hba1c: 6.6%. ECG showed Sinus rhythm with ventricular response 95 bpm (Figure 1).

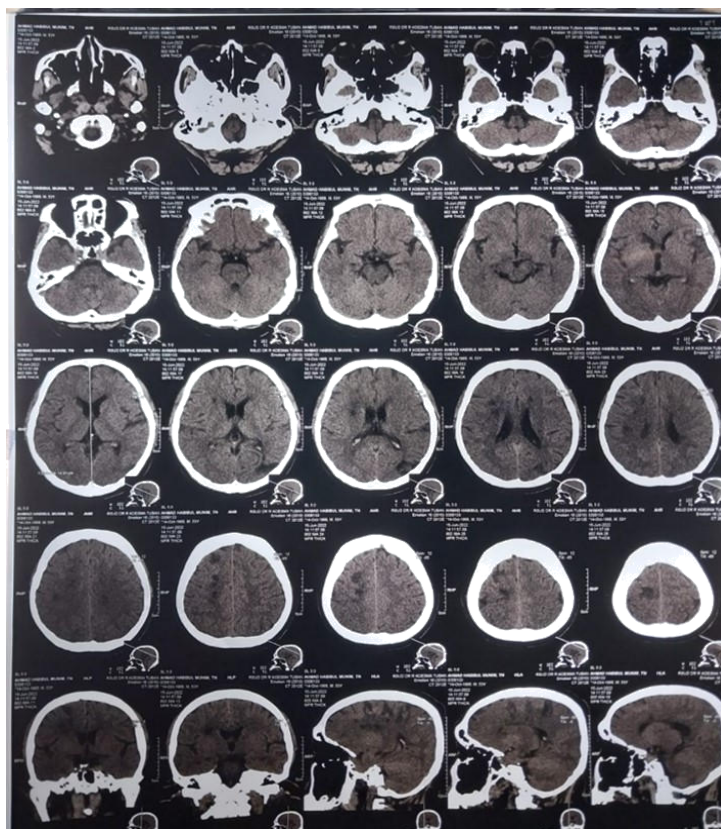
On Neurological status the awareness with GCS 456, Meningeal Stimulation negative, dysarthria, there is no paresis (-) of cranial nerves, with upper motoric function 5555/3333 and lower motoric function 5555/3333. Sensory nerves in normal limits, physiological reflex +2/+2 and pathological reflections: - / -. Ct scan showed Stroke infarction Frontoparietal right according to the right MCA territory (Figure 3).



**FIGURE 1:** Electrocardiography in ER Doctor Suyudi General Hospital.



**FIGURE 2:** Thorax x-ray.



**FIGURE 2:** Ct scan.

The patient was clinically diagnosed with Clinical Hemiparesis sinistra and diarrhea et causa stroke infarction, Hypertension, DM controlled, hypokalemi, and topical diagnosed with stroke Infarction Subkortikal frontoparietal lobus corresponding right of the right MCA territory, with etiological diagnosed with Stroke Infarction. The patient was treated with Head up 30 °, Oxygenation with Nasal cannula 3 LPM, IVF RL 500cc/24 hours, Loading Citicolin 1000mg Continue 3x 500mg, mecobalamin injection, omeprazole iv, drip KCL 25 mcg / 24 Hours. And oral spironolakton 1x25mg, candesartan 1x8mg, atrovastatin 1x20mg.

## DISCUSSION

Stroke rehabilitation is a comprehensive medical management and rehabilitation of disabilities caused by stroke through a neurorehabilitation approach with the goal of optimizing recovery and/or modifying the remaining symptoms so that the stroke survivor can independently perform functional activity, adapt to the environment, and live a quality life [1]. Forty percent of stroke patients are left with moderate functional impairments, while 15 to 30 percent are severely disabled [2]. Disability is a significant national issue. WHO estimates that between 7 and 10 percent of the world's population is disabled [3]. Obviously, this quantity is extremely concerning. According to the findings of the study Seamic Health Statistic (Int mint found japan1998), between 1991 and 1995, stroke became the leading cause of mortality in Indonesia and the leading cause of disability among adults [4]. In Indonesia, the incidence of stroke is increasing. With the expanding administration of science and technology in health, extensive vaginal survival has increased, despite the presence of severe residual symptoms [5]. As a result of ill dietary habits, a stressful lifestyle, and the absence of a sports culture due to a lack of time, the prevalence of strokes in the productive age shifts [6]. The purpose of this case study is to examine the Management of Medical Rehabilitation for Stroke Infarction Patients in Type C Hospitals.

After 6 months of rehabilitation Medical There was an increase in MMT from 5555/3333 of the upper parties and 5555/3333 of the lower extremity to 5555/5555 for the top extremities and 5555 /-5-5-5-5 for lower extremities. With the increase of MMT then there is an increase of the Score Barthel Index 19 which means light dependence. Patients receiving organized inpatient stroke unit care were more likely to survive, regain independence, and return home compared to those receiving a less organized service [9]. The Cochrane review also concluded, Acute stroke patients should be offered organized inpatient stroke unit care, typically provided by a coordinated multidisciplinary team operating within a discrete stroke ward that can offer a substantial period of rehabilitation, if required. severity.

Nonetheless, the examiners cautioned that there could be a wide range of outcomes due to varying rates of outcome and confidence intervals. In the most recent update of this systematic review, researchers from nearly all of the trials participated in an effort to ascertain why stroke unit care was superior. They found no differences in staffing levels or composition, but there was a tendency for assessment and therapy to commence earlier in organized settings [10].

## CONCLUSION

In patients Mr AH 53 years has been medical rehabilitation the acute and subacute phase that gives changes to the previous MMT and ADL dependence is being lighter. Early assessment and intervention are critical to optimize rehabilitation.

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