Background and purpose: An increasing interest in the potential benefits of cognitive motor interference (CMI) for stroke has recently been observed, but the efficacy of CMI for gait and balance is controversial. A systematic review and meta-analysis of randomized controlled trials was performed to estimate the effect of CMI on gait and balance in patients with stroke.

Methods: Articles in Medline, EMBASE, the Cochrane Library, Web of Science, CINAHL, PEDro and the China Biology Medicine disc were searched from 1970 to July 2014. Only randomized controlled trials examining the effects of CMI for patients with stroke were included, and no language restrictions were applied. Main outcome measures included gait and balance function.

Results: A total of 15 studies composed of 395 participants met the inclusion criteria, and 13 studies of 363 participants were used as data sources for the meta-analysis. Pooling revealed that CMI was superior to the control group for gait speed [mean difference (MD) 0.19 m/s, 95% confidence interval (CI) (0.06, 0.31), \( P = 0.003 \)], stride length [MD 12.53 cm, 95% CI (4.07, 20.99), \( P = 0.004 \)], cadence [MD 10.44 steps/min, 95% CI (4.17, 16.71), \( P = 0.001 \)], centre of pressure sway area [MD \(-1.05\) cm², 95% CI \((-1.85, -0.26)\), \( P = 0.01\)] and Berg balance scale [MD 2.87, 95% CI (0.54, 5.21), \( P = 0.02 \)] in the short term.

Conclusion: Cognitive motor interference is effective for improving gait and balance function for stroke in the short term. However, only little evidence supports assumptions regarding CMI’s long-term benefits.
methodology. Another systematic review [8] that included 28 papers concluded that the effectiveness of CMI in improving physical functioning in older adults is limited. To date, however, no systematic review and meta-analysis has examined CMI for gait and balance function in patients with stroke.

At present, no data have proved the effectiveness of CMI for improving gait and balance in contrast to cognitive exercise, motor exercise or no intervention in patients with stroke. Therefore a systematic review and meta-analysis was conducted to determine the effect of CMI on gait and balance in stroke.

Methods

Search strategy

Relevant papers were searched in the following data sources (1970 to July 2014): Medline, the Cochrane Library, EMBASE, CINAHL, Web of Science, Physiotherapy Evidence Database scale (PEDro) and China Biology Medicine disc. The search was limited to randomized controlled trials (RCTs) but had no language restrictions. The full electronic search strategies for all databases are provided in Appendix S1. In addition, journals of rehabilitation medicine, neurology and sport science were searched by hand.

Inclusion criteria

1. Types of studies: published papers with completed RCTs were included. No restrictions were made regarding language or the date of the trial.
2. Types of participants: papers with stroke subjects aged over 18 years were included.
3. Types of interventions: only papers that compared an intervention group which performed CMI and a control group which performed a single-task exercise (e.g. walking or strength and balance exercises) or no treatment were considered. CMI was the simultaneous performance of a cognitive task and a motor task, and each task was separate [3]. In the classic CMI, participants performed a motor task (e.g. walking) whilst answering a series of simple addition/subtraction questions (e.g. 100 - 7 = 93) [9].
4. Types of outcome measures: the primary outcomes were gait variables and balance function. The secondary outcomes were activities of daily living, such as the functional independence measure (FIM) scale.

Selection of studies

Two authors independently used the same selection criteria to screen titles, abstracts and full papers of the relevant articles. A study that did not meet the inclusion criteria was removed. Any disagreement was resolved through discussion. A third author was consulted if disagreement persisted.

Data extraction and quality assessment

The following data were extracted: study characteristics (e.g. author and year), participant characteristics (e.g. age and number of subjects), description of interventions, duration of trial period, types of outcomes assessed and time point. The Cochrane Collaboration recommendations [10,11] were used to evaluate the risk of bias for inclusion in the systematic review. Two review authors independently extracted the data and assessed the methodological quality of each study. Consulting a third author was necessary when a disagreement occurred.

Statistical analysis

Review Manager Software (RevMan5.2, Cochrane Collaboration, Oxford, UK) was used to conduct the meta-analysis. Continuous outcomes was analysed by calculating the mean difference (MD) between groups when the same instrument was used to measure outcomes or the standardized mean difference (SMD) when different instruments were used to measure the outcomes. The chi-squared test and the $I^2$ statistic were used to assess heterogeneity amongst the studies. The outcome measures from the individual studies were combined through meta-analysis using a random effects model. A $P$ value < 0.05 indicates a significant statistical difference. Sensitivity analysis was performed by removing each study individually to assess the consistency and quality of the results. The Egger’s regression test was used to assess publication bias.

Systematic review registration http://www.crd.york.ac.uk/PROSPERO. PROSPERO registration number CRD42012002606.

Results

Study identification

The process of identifying eligible studies is outlined in Fig. 1. Amongst 1005 identified records (including titles and abstracts) from Medline, EMBASE, the Cochrane Library, Web of Science, CINAHL, PEDro, the China Biology Medicine disc and manual search, 44 potentially eligible studies were included. After reviewing the full papers of the 44 potential articles, 15 papers [6,7,12–24] fulfilled the inclusion criteria. The remaining 29 papers were excluded because their
studies included participants with other neurological diseases (e.g. Parkinson’s disease and cognitive impairment), normal elder adults and participants who were not stroke patients and did not compare CMI with a control group. Table 1 presents the characteristics of each study included.

**Risk of bias in included studies**

Briefly, every study was reported as random allocation. Nine papers of the included trials failed to adopt allocation concealment, whereas eight papers tried to blind the assessors to the allocated treatment. Full details of the methodological quality of these trials are shown in Table 2.

**Gait variables**

*Gait speed*

Six studies [12,16,19,20,23,24] were included to estimate the effect of CMI on gait speed. The results showed that CMI for gait speed was better than the control group in a random effects model [MD 0.19 m/s, 95% confidence interval (CI) (0.06, 0.31), \( P = 0.003 \)] (Table 3; Fig. 2a). A sensitivity analysis was performed and it was found that the significance of the results was not changed when studies were removed one by one.

*Stride length*

Three studies [12,16,17] were included to estimate the effect of CMI on stride length. Results showed that CMI improved stride length better than the control group in a random effects model [MD 12.53 cm, 95% CI (4.07, 20.99), \( P = 0.004 \)] (Table 3; Fig. 2b). It was affected by one study [12] in the sensitivity analysis. Therefore it provided weak evidence of CMI on stride length.

*Cadence*

Three studies [12,16,17] were included to estimate the effect of CMI on cadence. The results showed that
<table>
<thead>
<tr>
<th>First author, year</th>
<th>Patient characteristics, sample size</th>
<th>Intervention</th>
<th>Duration of trial period</th>
<th>Outcome</th>
<th>Time point</th>
</tr>
</thead>
</table>
| Her 2011 [6]       | Source: hospital rehabilitation department, 38 patients (G1 = 13, G2 = 12, G3 = 13)  
Mean age (SD): G1 = 63.5 years (6.4), G2 = 64.8 years (5.2), G3 = 64.5 years (4.8)  
Mean time of post-stroke (SD): G1 = 2.76 years (0.48), G2 = 2.54 years (0.62) | G1: cognitive motor exercise  
G2: motor exercise  
G3: cognitive exercise | Three times a week for 6 weeks | Balance (COP sway area, BBS) and FIM | 6 weeks |
| Zheng 2012 [7]     | Source: community groups, 92 patients (G1 = 45, G2 = 47)  
Mean age (SD): G1 = 69.11 years (5.01), G2 = 68.61 years (4.62)  
Mean time of post-stroke (SD): G1 = 4.08 years (3.13), G2 = 4.68 years (7.4) | G1: cognitive motor exercise  
G2: single-task balance exercise | Three times a week for 8 weeks | Balance performance (COP sway area, COP sway distance) | 8 weeks |
| Yang 2007 [12]     | Source: community groups, 25 patients (G1 = 13, G2 = 12)  
Mean age (SD): G1 = 59.46 years (11.83), G2 = 59.17 years (11.98)  
Mean time of post-stroke (SD): G1 = 4.92 years (4.53), G2 = 9.63 years (8.97) | G1: cognitive motor exercise  
G2: no intervention | Three times a week for 4 weeks | Gait (walking speed, cadence, stride time and stride length) | 4 weeks |
| Evans 2009 [13]    | Source: not specified, 19 patients (G1 = 10, G2 = 9)  
Mean age (SD): G1 = 44.4 years (8.51), G2 = 45.11 years (9.73)  
Mean time of post-stroke (SD): G1 = 4.08 years (3.13), G2 = 4.68 years (7.4) | G1: cognitive motor exercise  
G2: treatment as usual | Five times a week for 5 weeks | Balance (2-min walk) | 5 weeks |
| Sco 2012 [14]      | Source: hospital, 40 patients (G1 = 20, G2 = 20)  
Mean age (SD): G1 = 55.8 years (3.6), G2 = 56.7 years (2.4)  
Mean time of post-stroke (SD): G1 = 0.6 years (0.2), G2 = 0.56 years (0.2) | G1: cognitive motor exercise  
G2: single-task balance exercise | Five times a week for 4 weeks | Balance performance (COP sway area and COP sway distance) | 4 weeks |
| Cho 2012 [15]      | Source: stroke unit, 22 patients (G1 = 11, G2 = 11)  
Mean age (SD): G1 = 62.56 years (8.35), G2 = 63.18 years (6.87)  
Mean time of post-stroke (SD): G1 = 1.05 years (0.22), G2 = 1.05 years (0.02) | G1: cognitive motor exercise + standard rehabilitation programme  
G2: standard rehabilitation programme | Five times a week for 6 weeks | Balance (BBS, TUGT, COP sway) | 6 weeks |
| Cho 2013 [16]      | Source: hospital, 14 patients (G1 = 7, G2 = 7)  
Mean age (SD): G1 = 64.57 years (4.35), G2 = 65.14 years (4.74)  
Mean time of post-stroke (SD): G1 = 0.79 years (0.19), G2 = 0.86 years (0.23) | G1: cognitive motor exercise + standard rehabilitation programme  
G2: standard rehabilitation programme | Three times a week for 6 weeks | Gait (gait speed, stride length, step length, cadence), balance (BBS, TUGT) | 6 weeks |
| Kim 2009 [17]      | Source: not specified, 22 patients (G1 = 11, G2 = 11)  
Mean age (SD): G1 = 52.42 years (10.09), G2 = 51.75 years (7.09)  
Mean time of post-stroke (SD): G1 = 2.16 years (0.83), G2 = 2.02 years (0.74) | G1: cognitive motor exercise + conventional physical therapy  
G2: conventional physical therapy | Four times a week for 4 weeks | Gait (stride length, step length, cadence, step time), balance (BBS, 10-m walking, COP sway area, COP sway distance) | 6 weeks |

(continued)
<table>
<thead>
<tr>
<th>First author, year</th>
<th>Patient characteristics, sample size</th>
<th>Intervention</th>
<th>Duration of trial period</th>
<th>Outcome</th>
<th>Time point</th>
</tr>
</thead>
</table>
| Yang 2011 [18]    | Source: hospital, 14 patients (G1 = 7, G2 = 7)  
Mean age (SD): G1 = 56.3 years (10.2), G2 = 65.7 years (5.9)  
Mean time of post-stroke (SD): G1 = 1.41 years (0.72), G2 = 1.36 years (0.87) | G1: cognitive motor exercise (virtual reality treadmill training)  
G2: traditional treadmill training | Three times a week for 3 weeks | Balance (COP sway area, COP sway distance) | 3 weeks |
| Yang 2008 [19]    | Source: community groups, 20 patients (G1 = 11, G2 = 9)  
Mean age (SD): G1 = 55.45 years (11.25), G2 = 60.89 years (9.25)  
Mean time of post-stroke (SD): G1 = 5.93 years (4.17), G2 = 6.10 years (10.32) | G1: cognitive motor exercise (virtual reality treadmill training)  
G2: traditional treadmill training | Three times a week for 3 weeks | Gait (gait speed), balance (ABC) | 3 weeks  
4 weeks |
| Mirelman 2009 [20] | Source: not specified, 18 patients (G1 = 9, G2 = 9)  
Mean age (SD): G1 = 61.8 years (9.94), G2 = 61 years (8.32)  
Mean time of post-stroke (SD): G1 = 3.14 years (2.08), G2 = 4.85 years (2.19) | G1: cognitive motor exercise (virtual reality training)  
G2: traditional training | Three times a week for 4 weeks | Gait (gait speed, step length), balance (6-min walk) | 4 weeks |
| Jung 2012 [21]    | Source: not specified, 21 patients (G1 = 11, G2 = 10)  
Mean age (SD): G1 = 66.5 years (8.6), G2 = 63.6 years (5.1)  
Mean time of post-stroke (SD): G1 = 1.05 years (0.275), G2 = 1.28 years (0.39) | G1: cognitive motor exercise (virtual reality training)  
G2: traditional training | Five times a week for 3 weeks | Balance (TUGT, ABC) | 3 weeks |
| Mirelman 2010 [22] | Source: not specified, 18 patients (G1 = 9, G2 = 9)  
Mean age (range): 62 years (61–75)  
Time of post-stroke: greater than 2 years | G1: cognitive motor exercise (virtual reality training)  
G2: traditional training | Five times a week for 4 weeks | Gait (kinetic gait parameters) | 4 weeks |
| Xiao 2012 [23]    | Source: hospital, 12 patients (G1 = 6, G2 = 6)  
Mean age (SD): G1 = 55.83 years (10.78), G2 = 57.17 years (11.16)  
Mean time of post-stroke (SD): G1 = 0.12 years (0.06), G2 = 0.12 years (0.05) | G1: cognitive motor exercise (virtual reality treadmill training)  
G2: conventional physiotherapy | Five times a week for 3 weeks | Gait (gait speed) | 3 weeks |
| Jaffe 2004 [24]   | Source: community groups, 20 patients (G1 = 10, G2 = 10)  
Mean age (SD): G1 = 58.2 years (11.2), G2 = 63.2 years (8.3)  
Time of post-stroke: an average of 3.7 years duration post-stroke | G1: cognitive motor exercise (virtual reality treadmill training)  
G2: traditional treadmill training | Six sessions for 2 weeks | Gait (gait speed, step length, stride length), balance (6-min walk) | 2 weeks  
4 weeks |

ABC, Activities-specific Balance Confidence; BBS, Berg balance scale; COP, centre of pressure; FIM, functional independence measure; TUGT, timed up and go test.
CMI was better than the control group for improving cadence in a random effects model \([MD \ 10.44 \text{ steps/min}, \ 95\% \ CI \ (4.17, \ 16.71), \ P = 0.001]\) (Table 3; Fig. 2c). Sensitivity analysis revealed that the pooled result was stable when studies were removed one by one.

**Step length**
Three studies \([16, 17, 20]\) were included to estimate the effect of CMI on step length. No significant difference was observed between CMI and the control group for step length in a random effects model \([MD \ 2.61 \text{ cm}, \ 95\% \ CI \ (-1.93, \ 7.14), \ P = 0.26]\) (Table 3, Fig. S1a). Sensitivity analysis found that the pooled result was not influenced by individual trials.

**Balance**

### Centre of pressure sway area
Four studies \([6, 7, 14, 17]\) were included to estimate the effect of CMI on centre of pressure (COP) sway area. The results showed that CMI was better than the control group on COP sway area in a random effects model \([SMD \ 1.05, \ 95\% \ CI \ (-1.85, \ 0.26), \ P = 0.01]\) (Table 3; Fig. 3a). Sensitivity analysis found that the significance of the result was changed when one study \([7]\) was removed, which offered inferior evidence for the effect of CMI on COP sway.

### Centre of pressure sway distance
Six studies \([7, 14, 15, 17]\) were included to estimate the effect of CMI on COP sway distance. No significant

---

**Table 2** Risk of bias assessment of included studies

<table>
<thead>
<tr>
<th>First author, year</th>
<th>Random sequence generation</th>
<th>Allocation concealment</th>
<th>Blinding of participants and personnel</th>
<th>Blinding of outcome assessment</th>
<th>Incomplete outcome data</th>
<th>Selective reporting</th>
<th>Other bias</th>
<th>Risk of bias</th>
</tr>
</thead>
<tbody>
<tr>
<td>Her 2011 [6]</td>
<td>Low</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
<td>Unclear</td>
<td>High</td>
</tr>
<tr>
<td>Zheng 2012 [7]</td>
<td>Low</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Unclear</td>
<td>High</td>
</tr>
<tr>
<td>Yang 2007 [12]</td>
<td>Low</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
<td>Unclear</td>
<td>High</td>
</tr>
<tr>
<td>Evans 2009 [13]</td>
<td>Low</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Unclear</td>
<td>High</td>
</tr>
<tr>
<td>Seo 2012 [14]</td>
<td>Low</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
<td>Unclear</td>
<td>High</td>
</tr>
<tr>
<td>Cho 2012 [15]</td>
<td>Low</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
<td>Unclear</td>
<td>High</td>
</tr>
<tr>
<td>Cho 2013 [16]</td>
<td>Low</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Unclear</td>
<td>High</td>
</tr>
<tr>
<td>Kim 2009 [17]</td>
<td>Low</td>
<td>High</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Unclear</td>
<td>High</td>
</tr>
<tr>
<td>Yang 2011 [18]</td>
<td>Low</td>
<td>High</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Unclear</td>
<td>High</td>
</tr>
<tr>
<td>Yang 2008 [19]</td>
<td>Low</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Unclear</td>
<td>High</td>
</tr>
<tr>
<td>Mirelman 2009 [20]</td>
<td>Low</td>
<td>High</td>
<td>High</td>
<td>Low</td>
<td>Unclear</td>
<td>Low</td>
<td>Unclear</td>
<td>High</td>
</tr>
<tr>
<td>Jung 2012 [21]</td>
<td>Low</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Unclear</td>
<td>High</td>
</tr>
<tr>
<td>Mirelman 2010 [22]</td>
<td>Low</td>
<td>High</td>
<td>High</td>
<td>Low</td>
<td>Unclear</td>
<td>Low</td>
<td>Unclear</td>
<td>High</td>
</tr>
<tr>
<td>Xiao 2012 [23]</td>
<td>Low</td>
<td>High</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
<td>Unclear</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Jaffe 2004 [24]</td>
<td>Low</td>
<td>High</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
<td>Unclear</td>
<td>Low</td>
<td>High</td>
</tr>
</tbody>
</table>

**Table 3** Summary of results

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Trials</th>
<th>Participants</th>
<th>Statistical method</th>
<th>Effect estimate</th>
<th>Heterogeneity</th>
<th>Effect P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gait speed</td>
<td>6 [12, 16, 19, 20, 23, 24]</td>
<td>112</td>
<td>Mean difference (IV, random, 95% CI)</td>
<td>0.19 [0.06, 0.31]</td>
<td>36%, 0.17</td>
<td>0.003</td>
</tr>
<tr>
<td>Stride length</td>
<td>3 [12, 16, 17]</td>
<td>61</td>
<td>Mean difference (IV, random, 95% CI)</td>
<td>12.53 [4.07, 20.99]</td>
<td>9%, 0.33</td>
<td>0.004</td>
</tr>
<tr>
<td>Cadence</td>
<td>3 [12, 16, 17]</td>
<td>61</td>
<td>Mean difference (IV, random, 95% CI)</td>
<td>10.44 [4.17, 16.71]</td>
<td>0%, 0.86</td>
<td>0.001</td>
</tr>
<tr>
<td>Step length</td>
<td>3 [16, 17, 20]</td>
<td>54</td>
<td>Mean difference (IV, random, 95% CI)</td>
<td>2.61 [−1.90, 7.12]</td>
<td>1%, 0.36</td>
<td>0.26</td>
</tr>
<tr>
<td>COP sway area</td>
<td>4 [6, 7, 14, 17]</td>
<td>270</td>
<td>Standardized mean difference (IV, random, 95% CI)</td>
<td>−1.05 [−1.85, −0.26]</td>
<td>88%, &lt;0.001</td>
<td>0.01</td>
</tr>
<tr>
<td>COP sway distance</td>
<td>4 [7, 14, 15, 17]</td>
<td>276</td>
<td>Standardized mean difference (IV, random, 95% CI)</td>
<td>−0.49 [−1.10, 0.12]</td>
<td>81%, &lt;0.001</td>
<td>0.11</td>
</tr>
<tr>
<td>BBS</td>
<td>4 [6, 15–17]</td>
<td>96</td>
<td>Mean difference (IV, random, 95% CI)</td>
<td>2.87 [0.54, 5.21]</td>
<td>50%, 0.11</td>
<td>0.02</td>
</tr>
<tr>
<td>TUGT</td>
<td>3 [15, 16, 21]</td>
<td>57</td>
<td>Mean difference (IV, random, 95% CI)</td>
<td>−0.98 [−3.83, 1.87]</td>
<td>32%, 0.23</td>
<td>0.50</td>
</tr>
<tr>
<td>ABC</td>
<td>2 [19, 21]</td>
<td>41</td>
<td>Mean difference (IV, random, 95% CI)</td>
<td>7.27 [−5.95, 20.48]</td>
<td>77%, 0.04</td>
<td>0.28</td>
</tr>
</tbody>
</table>

ABC, Activities-specific Balance Confidence scale; BBS, Berg balance scale; CI, confidence interval; COP, centre of pressure; IV, inverse variance; TUGT, timed up and go test.
difference was observed between CMI and the control group on COP sway distance in a random effects model [SMD $-0.49$, 95% CI $(-1.10, 0.12)$, $P = 0.11$] (Table 3; Fig. S1b). It was affected by one study [15] in the sensitivity analysis. Hence, it is necessary to provide more evidence to make judgements about the effect of CMI on COP sway distance.

**Berg balance scale (BBS)**
Four studies [6,15–17] were included to estimate the effect of CMI on the BBS. The results showed that CMI was better than the control group on the BBS in a random effects model [MD $2.87$, 95% CI $(0.54, 5.21)$, $P = 0.02$] (Table 3; Fig. 3b). Sensitivity analysis revealed that the pooled result was influenced by individual trials. Thus more evidence is needed to ensure the influence of CMI on the BBS.

**Timed up and go test (TUGT)**
Three studies [15,16,21] were included to estimate the effect of CMI on the TUGT. No significant difference was observed between CMI and the control group for the TUGT in a random effects model [MD $-0.98$ s, 95% CI $(-3.83, 1.87)$, $P = 0.50$] (Table 3; Fig. S1c). Sensitivity analysis revealed that the pooled result was not influenced by individual trials.

**Activities-specific Balance Confidence (ABC) scale**
Two studies [19,21] were included to estimate the effect of CMI on the Activities-specific Balance Confidence (ABC) scale. No significant difference was observed between CMI and the control group for ABC in a random effects model [MD $7.27$, 95% CI $(5.95, 20.48)$, $P = 0.28$] (Table 3; Fig. S1d).

**Other walk test**
One study [17] evaluated the effect of CMI on a 10-m walking test, which showed that CMI could improve in the 10-m walking test compared with the control group. Another study [20] assessed the effect of CMI on a 6-min walking test, which showed that CMI
could improve in the 6-min walking test compared with the control group. Another study [19] assessed the effect of CMI on a 400-m walking test, which showed that CMI could improve in the 400-m walking test compared with the control group.

Activities of daily living

One study [10] evaluated the effect of CMI on FIM, which showed that CMI could improve on FIM compared with the control group.

Publication bias

Egger’s regression test did not show any publication bias for gait speed (asymmetry test \( P = 0.337 \)), stride length (asymmetry test \( P = 0.874 \)), cadence (asymmetry test \( P = 0.748 \)), step length (asymmetry test \( P = 0.869 \)), COP sway area (asymmetry test \( P = 0.501 \)), COP sway distance (asymmetry test \( P = 0.088 \)), BBS test (asymmetry test \( P = 0.598 \)) and TUGT (asymmetry test \( P = 0.92 \)).

Discussion

A variety of exercise programmes were used to improve gait and balance function in patients with stroke. Previous systematic reviews had focused on single-task exercise programmes (e.g. strength and balance exercises). However, most people were more likely to fall when performing cognitive motor tasks in most daily activities. At present, an increasing interest in the potential benefits of CMI for stroke has been observed, and some papers [6,7] have suggested that CMI could improve gait and balance function for patients with stroke compared with a single-task exercise. But the efficacy of CMI for gait and balance is controversial. Therefore, this systematic review and meta-analysis provides evidence from relevant papers assessing CMI versus a single-task exercise or no intervention.

Our systematic review of papers from 15 RCTs, which covered 395 participants, provided evidence supporting the effect of CMI for improving gait and balance in stroke. Statistically significant differences were found on comparing CMI to a control group for 10 outcomes, including gait speed, stride length, cadence, performance in BBS, COP sway area, 2-min walk, 6-min walk, 10-m walk, 400-m walk and FIM. The improvements seen for gait speed, BBS, COP sway area, walk test and FIM were at levels that may signify clinical importance for stroke. In addition, no serious complications were observed in the 15 papers which investigated adverse events. By contrast, several other balance outcome measures (e.g. the ABC scale and TUGT) showed no significant benefit on
comparing CMI with a control group. However, the number of included studies and participants were insufficient to decide the overall effect of CMI.

Strengths and limitations
To our knowledge, this study is the first systematic review and meta-analysis to estimate the effects of CMI for gait and balance function in stroke by comparing with other treatments or no intervention. The past [5,8] systematic reviews either did not compare CMI to a control group or focused on qualitative synthesis rather than meta-analysis. In contrast to previous reviews [5,8], all the papers of this review only considered patients with stroke, and most papers included in this review are new. A meta-analysis of the effects of CMI compared with other treatments or no intervention was performed. And this review was conducted in accordance with PRISMA guidelines (Data S1).

Our systematic review has some limitations, however. First, the systematic review is limited by the quality of the included trials. A single study tried to blind the subjects, and no study blinded the therapists; six of the 15 studies conducted concealed allocation, and two of the 15 studies conducted intention-to-treat analyses. In addition, most of the papers included were within the last 3 years, but high quality studies were still insufficient. Secondly, the total number of patients was not large; thus, identifying small disparities between the effects of CMI and the control group was difficult. Because there were insufficient studies, subgroup analyses comparing CMI versus a single-task exercise or comparing CMI versus no intervention were not conducted. Thirdly, longer-term outcomes on gait and balance function could not be assessed as most studies had short intervention durations and short follow-up periods; in fact, the duration of follow-up was from 2 weeks to 8 weeks for all the studies.

Implications for research
Overall, high quality papers were still insufficient in our systematic review. Future studies should improve methodological standards which reduce possible biases. The following standards should be included: blind assessors; concealed allocation; adequate follow-up; measures to reduce withdrawals; intention-to-treat analysis; and between-group comparisons. In addition, papers should adhere to generally accepted standards of reporting clinical trials.

As previously mentioned, the sample size of most studies in this meta-analysis was small, and many studies had a short follow-up period. Therefore some large-scale RCTs are needed. To assess how long any improvement intervention may last based on CMI, follow-up sessions with longer durations should be performed for patients with stroke. Additionally, several different training programmes are currently in use for CMI, which may lead to different results. Thus, a systematic review and meta-analysis of different CMIs is necessary to determine the optimal intervention approach in stroke.

Conclusions and implications for practice
In our systematic review, statistically significant differences between CMI and the control group were found with regard to the following outcomes: gait speed, stride length, cadence, performance in BBS, COP sway area, 2-min walk, 6-min walk, 10-m walk, 400-m walk and FIM. Thus, our meta-analysis results should be useful for stroke patients and for medical staff and healthcare decision makers in coming up with effective exercise regimes for this age group.

Acknowledgements
This study was supported by the Key Laboratory of Exercise and Health Sciences (Shanghai University of Sport), the Ministry of Education, the First-class Disciplines of Shanghai Colleges and Universities (Psychology) and the Key Disciplines Group Construction Project of Pudong Health Bureau of Shanghai (Grant no. PWZxkq2011-02).

Disclosure of conflicts of interest
The authors declare no financial or other conflicts of interest.

Supporting Information
Additional Supporting Information may be found in the online version of this article:
Appendix S1. Search strategies for all databases.
Figure S1. Meta-analyses of cognitive motor interference on gait and balance function.
Data S1. PRISMA 2009 checklist.
References


