EVALUATION OF SUBTLE MOTOR DEFICIT SIGNS IN PATIENTS WITH MONOHEMISPHERIC BRAIN TUMOR (ABSTRACT)* . DISSERTATION. RIO DE JANEIRO, 2007.

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Introduction: One of the several functions of the physical therapist is to identify specific lesions responsible for pain, paralysis, or paresis. This is followed by an evaluation the presentation and integrity of the systems and structures involved, as well as estimating the patient’s performance level in his daily occupational and recreational life. Identifying the motor deficit established in the patient’s most severe expression does not pose great difficulty, due to the stereotypical aspect in which it is presented. On the other hand, the identification of motor deficits that are subtle to the point that they are not even recognized by the subjects themselves becomes a challenge when using only muscular force tests by confrontation and counter-resistance, which are part of the conventional neurolological examination.

Objective: This prospective study has the objective of evaluating the sensitivity and the specificity of a series of semiologic tests focusing on subtle motor deficits in patients with monohemispheric cerebral tumors.

Method: We used a blind design to study 94 subjects randomly selected from the Neurosurgery/Neurology ambulatory of INCa, and they were divided in two groups: 1) patients with monohemispheric cerebral tumor with more than 30 days of evolution and no apparent motor deficit (n=60) and 2) individuals without cerebral tumor (n=30). All subjects underwent a brain magnetic resonance or computed tomography examination, sometimes both. Four individuals were removed from the sample. The Author had no access to clinic histories, neurologic examinations, brain image tests, or diagnoses. Following the mini-mental status examination (Folstein, 1975, required minimum score: 25), thirteen tests were sequentially performed: Spasticity of Conjugate Gaze (SEOC); Platism Sign (SP); Forearm Rolling Test (SRA); Souques Intersosseous Sign (SIS); Pronator Drifting Test (SPr); Mayer Sign (SM); Finger Tapping Sign (SBD); Foot Tapping Sign (SBP); Babinski Sign (SB); Chaddock Sign (SC); Digit Quinti Sign (SBD); and the Digit Quinti Rolling Sign (SRQD).
Results: The sensitivity, specificity, and predictive values of each sign was calculated. The most sensitive tests were: the Digit Quinti Sign (sensitivity 0.51 (Confidence Interval 95%, 0.41 to 0.61)); the Pronator Drifting Test (0.41 (0.31 to 0.51)); the Finger Rolling Test (0.41 (0.31 to 0.51)); the Souques Interosseous Sign (0.23 (0.14 to 0.32)); and the Foot Tapping Test (0.23 (0.14 to 0.32)). The tests with greatest specificity were: SQD 0.70 (0.61 to 0.79); SPr 0.96 (0.92 to 0.99); SRA 0.93 (0.88 to 0.98); SIS 0.80 (0.72 to 0.88); and SBP 0.93 (0.88 to 0.98). The agreement measurement among the three most sensitive signs was 21%.

Conclusion: The SRQ, the SPr, and the SRA are simple tests to perform and easy to be interpreted. Their positivity in individuals without apparent motor deficit may point the therapist towards other diagnostic investigations to objectively detect monohemispheric cerebral lesion.

Key words: subtle motor deficit, cerebral tumor, neurologic semiology.


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Introduction: Narcolepsy is a chronic neurological condition whose main symptom is excessive daytime sleepiness, associated with cataplexy, sleep paralysis and hypnagogic hallucinations. The prevalence is between 1:2,000 and 1:40,000 individuals, with onset during childhood through adulthood. Narcolepsy is caused by a deficit of orexin (hypocretin) in lateral hypothalamus cells. Patients with narcolepsy have trouble remaining alert and awake during routine and monotonous tasks, with risks of accidents leading to serious social loss and impact on work and social-family relations in the perception of quality of life.

Purpose: To evaluate: a) the perception or quality of life in patients with narcolepsy; b) the perception of social impact; c) the existence of associations between socio-economic profile, perception of quality of life and perception of social impact; d) sleeping patterns.

Method: Forty patients with narcolepsy were evaluated, of which 28 women and 12 men, with an average age of 42. The instruments used were the Social Service Database Questionnaire of the Social Service Medical Division IC/HC; the WHOQOL-Bref Quality of Life Evaluation Questionnaire, the Social Impact Evaluation Questionnaire and the Giglio Adult Sleep Questionnaire.

Results: This study demonstrated the conclusion at next.

Conclusion: 1) narcolepsy brings about compromised quality of life for patients, impairing physical and emotional functions, interfering in working conditions and family dynamics; 2) narcolepsy produces a negative social impact on various spheres of patients’ lives, compromising instrumental activities of daily life and work situations; 3) There was no association of socio-economic condition as a determining factor in the perception of quality of life; 4) persons with narcolepsy have a higher degree of dissatisfaction in relation to sleeping pattern, such as fragmented sleep, nighttime awakenings and the presence of parasomnias.

Key words: narcolepsy; sleep; sleep disorders; quality of life.


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