

dex. Evaluation of quantitative standards at the polysomnography included the sleep myoclonus periodicity, the apnea-hypopnea index, and digital oximetry. At the statistical analyses were used the Parson's Chi Square, Student T, and the Mann-Whitney, with significant level of 5%.

Results: 126 men and 127 women with Parkinson disease, 125 men and 121 women at the control group were evaluated. The average age was 68 years old. The disease time was of 6.06 ± 5.12 years. Bedtime, time to fall asleep, and sleep duration were similar in both groups. The sleep quality was impaired in Parkinson disease ($p > 0.001$). The number of awakenings was higher the Parkinson patients ($p = 0.001$). Insomnia and excessive daytime sleepiness were more common in Parkinson disease, with significant statistical differences. Complaints related to restless legs and REM behavior disorder were higher in Parkinson group patients. The Epworth Sleepiness Scale scores were similar in both groups. The Pittsburgh Sleep Quality Index showed the Parkinson disease group as poor sleeper ($p < 0.001$). The insomnia was linked with movement difficulties, illness time and Levodopa dosage. The diurnal sleepiness was re-

lated to the time of the illness and to the Hoehn & Yahr scale. At the polysomnography, the total sleeping time was decreased at the Parkinson disease group ($p < 0.001$). The total time awake and sleep latency were higher at the Parkinson disease, respectively $p < 0.001$ and $p = 0.0012$. REM latency and number of awakenings were similar in both groups. The stages 1 and 2 of the sleep were higher at the Parkinson disease group with sleep efficacy impairment ($p < 0.0001$). Significant statistical differences in percentage of deep (stages 3 and 4) sleep and REM sleep were present. The periodic legs movement index and the obstructive sleep apnea index did not show significant differences. REM sleep without atonia was detected in 11 (7.1%) and central apnea in 3 (1.92%) of the patients.

Conclusion: The sleep impairment is a relevant finding in Parkinson disease. Characteristically, insomnia and the excessive daytime sleepiness were predominant. The polysomnographic findings show intense impairment of the sleep architecture within patients with Parkinson disease.

Key words: Parkinson disease, sleep, sleep disorders, insomnia.

*Sono e suas alterações na Doença de Parkinson. (Resumo). Tese de Doutorado, Universidade Estadual de Londrina (UEL) (Área: Medicina e Ciências da Saúde). Orientador: Damácio Ramón Kaimen Maciel; Co-Orientador: Rubens Reimão.

**Address: Rua dos Bogaris 38, 04047-020 São Paulo SP, Brasil. (E-mail: reimaorubensneuro@yahoo.com).

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

ELIANA TEIXEIRA MARANHÃO **

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 neurological 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 (SQD); 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); SP_r 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 SR_Q, the SP_r, 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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** Address: Avenida Canal de Marapendi, 1680/1802. 22631-050 Rio de Janeiro RJ, Brasil. (E-mail: limaranhao@gmail.com).

NARCOLEPSY: EVALUATION OF THE QUALITY OF LIFE AND SOCIAL IMPACT (ABSTRACT)*. DISSERTATION. SÃO PAULO, 2007.

*HELOÍSA HELENA DAL ROVERE***

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.

*Narcolepsia: avaliação da qualidade de vida e impacto social. Dissertação de Mestrado. Faculdade de Medicina da Universidade de São Paulo (FMUSP) (Área de concentração: Neurologia). Orientador: Rubens Reimão.

**Address: Rua dos Bogaris 38 – 04047-020 São Paulo SP, Brazil. (E-mail: hhrovere@yahoo.com.br).

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