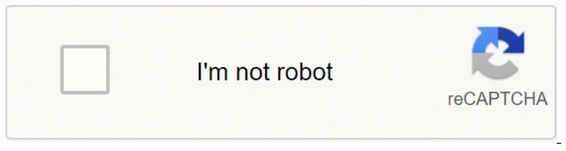

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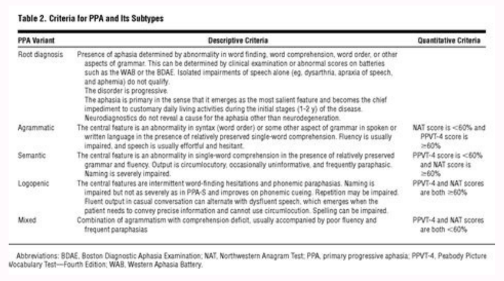


Table 2. Criteria for PPA and Its Subtypes

PPA Variant	Descriptive Criteria	Quantitative Criteria
Root diagnosis	Presence of aphasia determined by abnormality in word finding, word comprehension, word order, or other aspects of grammar. This can be determined by clinical examination or abnormal scores on batteries such as the WAB or the BDAE. Isolated impairments of speech alone (eg, dysarthria, apraxia of speech, and aphemia) do not qualify. The disorder is progressive. The aphasia is primary in the sense that it emerges as the most salient feature and becomes the chief impediment to customary daily living activities during the initial stages (1-2 y) of the disease. Neurodiagnostics do not reveal a cause for the aphasia other than neurodegeneration.	
Agrammatic	The central feature is an abnormality in syntax (word order) or some other aspect of grammar in spoken or written language in the presence of relatively preserved single-word comprehension. Fluency is usually impaired, and speech is usually effortful and hesitant.	NAT score is <60% and PPVT-4 score is >60%
Semantic	The central feature is an abnormality in single-word comprehension in the presence of relatively preserved grammar and fluency. Output is circumlocutory, occasionally uninformative, and frequently paraphasic. Naming is severely impaired.	PPVT-4 score is <60% and NAT score is >60%
Logopenic	The central features are intermittent word-finding hesitations and phonemic paraphasias. Naming is impaired but not as severely as in PPA-S and improves on phonemic cueing. Repetition may be impaired. Fluent output in casual conversation can alternate with dysfluent speech, which emerges when the patient needs to convey precise information and cannot use circumlocution. Spelling can be impaired.	PPVT-4 and NAT scores are both >60%
Mixed	Combination of agrammatism with comprehension deficit, usually accompanied by poor fluency and frequent paraphasias	PPVT-4 and NAT scores are both <60%

Abbreviations: BDAE, Boston Diagnostic Aphasia Examination; NAT, Northwestern Anagram Test; PPA, primary progressive aphasia; PPVT-4, Peabody Picture Vocabulary Test—Fourth Edition; WAB, Western Aphasia Battery.

Canadian Best Practice Recommendations for Stroke Care

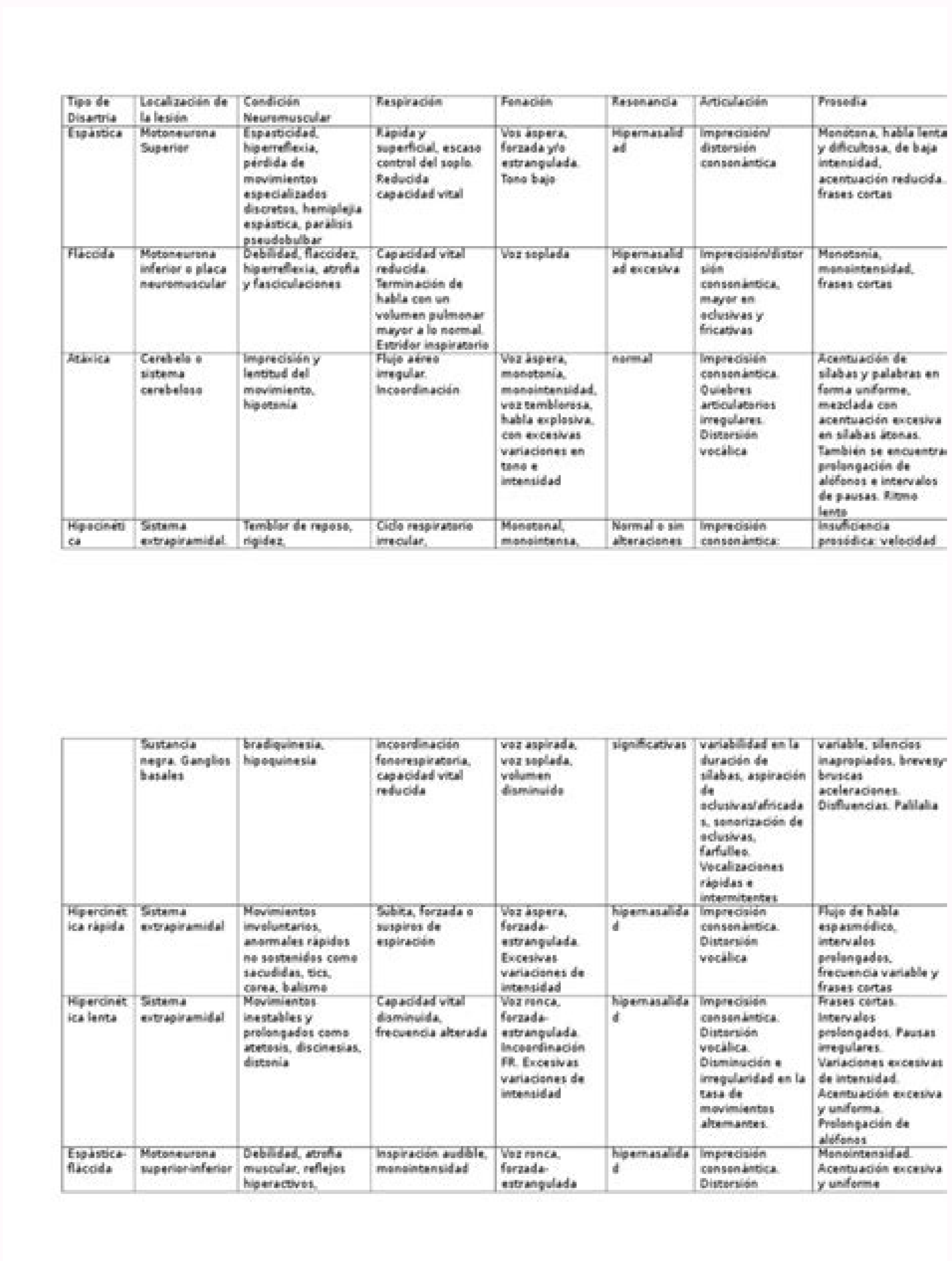
Heart & Stroke Foundation of Canada

Canadian Stroke Network

Aphasia Screening Tools

Canadian Best Practice Recommendations for Stroke Care 2011-2013 Update

Last Updated: June 19, 2013



Tipo de Disartria	Localización de la lesión	Condición Neuromuscular	Respiración	Fonación	Resonancia	Articulación	Prosodia
Espástica	Motoneurona Superior	Espasticidad, hiperreflexia, pérdida de movimientos especializados discretos, hemiplejia espástica, parálisis pseudobulbar	Rápida y superficial, escaso control del soplo. Reducida capacidad vital	Vos áspera, forzada y/o estrangulada. Tono bajo	Hipernasalidad	Imprecisión/ distorsión consonántica	Monotona, habla lenta y dificultosa, de baja intensidad, acentuación reducida. frases cortas
Fláccida	Motoneurona inferior o placa neuromuscular	Debilidad, flaccidez, hiperreflexia, atrofia y fasciculaciones	Capacidad vital reducida. Terminación de habla con un volumen pulmonar mayor a lo normal. Estridor inspiratorio	Voz soplada	Hipernasalidad excesiva	Imprecisión/distorsión consonántica, mayor en oclusivas y fricativas	Monotonía, monointensidad, frases cortas
Atáxica	Cerebelo o sistema cerebeloso	Imprecisión y lentitud del movimiento, hipotonía	Flujo aéreo irregular. Incoordinación	Voz áspera, monotonía, monointensidad, voz temblorosa, habla explosiva, con excesivas variaciones en tono e intensidad	normal	Imprecisión consonántica. Quiebres articulatorios irregulares. Distorsión vocálica	Acentuación de sílabas y palabras en forma uniforme, mezclada con acentuación excesiva en sílabas átonas. También se encuentra prolongación de alófonos e intervalos de pausas. Ritmo lento
Hipocinética	Sistema extrapiramidal. Sustancia negra. Ganglios basales	Temblor de reposo, rigidez, bradiquinesia, hipoquinesia	Ciclo respiratorio irrecular, incoordinación fonorespiratoria, capacidad vital reducida	Monotonal, monointensa, voz aspirada, voz soplada, volumen disminuido	Normal o sin alteraciones significativas	Imprecisión consonántica: variabilidad en la duración de sílabas, aspiración de oclusivas/africadas, sonorización de oclusivas, farfulleo. Vocalizaciones rápidas e intermitentes	Insuficiencia prosódica: velocidad variable, silencios inapropiados, breves y bruscas aceleraciones. Disfluencias. Palilalia
Hipercinética rápida	Sistema extrapiramidal	Movimientos involuntarios, anormales rápidos no sostenidos como sacudidas, tics, corea, balismo	Súbita, forzada o suspiros de espiración	Voz áspera, forzada-estrangulada. Excesivas variaciones de intensidad	hipernasalidad	Imprecisión consonántica. Distorsión vocálica	Flujo de habla espasmódico, intervalos prolongados, frecuencia variable y frases cortas
Hipercinética lenta	Sistema extrapiramidal	Movimientos inestables y prolongados como atetosis, discinesias, distonía	Capacidad vital disminuida, frecuencia alterada	Voz ronca, forzada-estrangulada. Incoordinación FR. Excesivas variaciones de intensidad	hipernasalidad	Imprecisión consonántica. Distorsión vocálica. Disminución e irregularidad en la tasa de movimientos alternantes.	Frases cortas. Intervalos prolongados. Pausas irregulares. Variaciones excesivas de intensidad. Acentuación excesiva y uniforme. Prolongación de alófonos
Espástica-fláccida	Motoneurona superior-inferior	Debilidad, atrofia muscular, reflejos hiperactivos,	Inspiración audible, monointensidad	Voz ronca, forzada-estrangulada	hipernasalidad	Imprecisión consonántica. Distorsión	Monointensidad. Acentuación excesiva y uniforme

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According to the data here shown, this scale has sufficient sensitivity and specificity to distinguish between patients with aphasia after an ICTUS and healthy patients / subjects with ICTUS without an aphasia. Without pretending to replace none of the traditional scales, MASTSP seems to provide sufficient information to design an initial approach to Logopeddia. Materials and methods all of 29 patients who had suffered a stroke and had aphasia after a left hemispherical injury were evaluated with MASTSP, the Boston Diagnostic Aphasia Examination and the symbolic test at the beginning and after Six months of rehabilitation. This same group (n = 12) was evaluated twice at the same time to check the test-retest reliability. The group of ACV patients with non-Afasso right hemisphere and the total control group were evaluated with MASTSP at the time of inclusion only. To evaluate the interobserver reliability, 12 of the Afatician patients were evaluated by 2 experts in Logopedia. The Mastest is the first validated test of aphasia detection for Estonian-speaking people, which are less than one million around the world. The Result Measurement Center in brain injuries. The results were used to determine the capacity of the test to detect significant clinical changes over time. In our case, the interobserver reliability and the retest â € scores were excellent, both for total and partial scores, as described in previous studies. we saw similar results with the rest of the tests in the battery we used. ConclusionsThe MASTsp is a measure lida vÃ lida Ti, Sisylana) Cor (CITSIRETCARHC GNITAREPO Reviecer Gnisu Tub, Ylevitcepser,% 49 DNA% 47 EREVITCREP HT5 EHT GNISU TSETSAM EHT FO YTICIFICEPS DNA YTIVITISNES EHT.) 001â € ™) 4.0â ±: SSENWEKS (PUORG TNEITAP CISAHPA EHT ROF TNEREFID SAW EVOW EHT, REVETBUS LLA NI GC EHT NAHT TNEMRIAPMI EROM DEWOHS PUORG + AHL EHT.) 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All curves showed statistically significant values for the area under the curve, with acceptable 95% confidence limits (Table 5). The MAST was designed to be used for serial assessments to detect changes in language abilities over time. Non-parametric methods (Kruskal¢ÃÂÂWallis test and Mann¢ÃÂÂWhitney test) were used to compare MAST scores due to their non-normal distribution. The MAST can be administered in 5 to 15 minutes. The version presented here maintains both the original structure of the 9 subtests and the original scoring system with a minimum score of 0 (suggesting severe aphasia) and a maximum of 100 (a normal individual). Information regarding the MAST was contributed by Methodist Rehabilitation Center. This easy-to-administer test makes use of 20 tokens in different sizes, 5 different colours and 2 shapes (squares and circles). 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