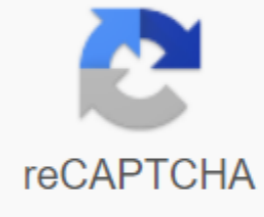




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## Cerebellar function test pdf

The cerebellum examination often appears in OSCEs, and you will need to identify the appropriate clinical signs using your screening skills. This cerebellum examination osce guide provides a clear step-by-step approach to the study of the cerebellum, with the included video demonstration. Mnemonic DANISH is a useful way to remember important moments to cover in the cerebellar examination: Dysdiadochokinesia Ataxia (gait and posture) Nystagmus Intention Tremor Slurred, staccato speech Hypotonia / heel-blue test Introduction To present yourself to the patient, including your name and role. Confirm the patient's name and date of birth. Explain briefly what will include a screening using a language convenient for patients. Get consent for the examination. Ask the patient to sit on a chair, about one arm's distance. Wash your hands. Ask the patient if they have any pain before starting a clinical examination. General Examination Clinical Signs Perform a Brief General Examination of the Patient, looking at clinical signs indicating a underlying pathology: Abnormal posture: may indicate the presence of truncal ataxia. Speech anomaly: Slurred speech staccato is characteristic of cerebellar disease. Scars: may indicate previous neurosurgery (often difficult to see because of the patient's hair). Gait: Pay attention to the patient's gait when they enter the room and take a seat, taking away any abnormalities (e.g. a broad gait in the cerebellar pathology). Facilities or equipment Look for facilities or equipment on or around the patient that can provide useful information about their medical history and current clinical condition: Walking Care: Cerebellar disease often causes balance problems (ataxia), resulting in patients using walking tools to stabilize themselves. Hearing aids: Hearing loss may be associated with a pathology that can affect the cerebellum (e.g., acoustic neuroma causing local cerebellar compression). Prescriptions: Issuing cards or personal prescriptions can provide useful information about the patient's latest medications. Ataxia is a neurological trait consisting of involuntary movements with irregular oscillator quality that interfere with the normal smooth trajectory of movement. Ataxia can be truncal (affecting the trunk) or appendicular (affecting the limbs): Truncal ataxia: affects the proximal musculature that is involved in gait stability. This form of ataxia is caused by damage to the cerebellar verma and its associated pathways (i.e. damage to the cerebellums of the middle line). Appendicular ataxia: affects the muscles of the arms and legs involved in controlling the movement of the limbs. This form of ataxia is caused by damage to the cerebellar hemispheres (i.e. lateral cerebellum lesions). Gait Score Gait Patient Patients With Cerebellum Disease at an increased risk of falls, so make sure to stay close to patient during assessment, so you can intervene if necessary. Ask the patient to go to the end of the exam room and then turn and walk back while you watch their gait paying attention to: Rack: Broad attackatic gait is usually associated with an average cerebellar pathology (e.g., multiple sclerosis or cerebellar regeneration secondary to chronic excess alcohol). Stability: Stunning, slow and unstable gait is typical for cerebellar pathology. With one-sided cerebellar disease, patients will believe in the direction of defeat. Turn: Patients with cerebellar disease will find it especially difficult to turn the maneuver. Tandem ('heel to heel') gait Ask the patient to go to the end of the exam room and back with the heels on his feet (known as tandem gait). Walking on the heels exacerbates the unsteadiness, which makes it easier to detect a more subtle ataxia. Tandem gait is particularly sensitive in detecting dysfunction of cerebellar verma (for example, caused by alcohol cerebellar degeneration). Cerebellar degeneration involves the progressive loss of Purkingier cells in the cerebellum. It has a wide range of causes including chronic alcohol abuse, nutrient deficiency (usually B12), paraneoplastic disorders and neurological diseases (e.g. multiple sclerosis, spinal corderellater ataxia). Typical clinical features include: Broad-based attackic gait Truncal ataxia dysmetry (inconsistency) nystagmus (abnormal eye movements) test Romberg test used to assess loss of proprioceptive or vestibular function (known as sensory ataxia). The test does not assess cerebellar function and is instead used to quickly test for evidence of sensory ataxia (i.e. non-cerebellar causes of balance problems). Romberg's test is based on the premise that a patient needs at least two of the following three senses to maintain balance while standing: Proprioception: awareness of one's body position in space. Vestibular function: the ability to know the position of the head in space. Vision: the ability to see your position in space. Romberg's test involves removing the sense of vision by asking the patient to close his eyes. As a result, if the patient has a deficiency in proprioception or vestibular function they will struggle to stay standing without visual input. Score 1. Position yourself within reach of the patient's weapons to allow you to intervene if they start to fall. 2. Ask the patient to put his feet together and keep their hands on their side (keep in mind that patients with truncal ataxia may struggle to do so, however, this type of instability is not the same as Romberg's positive sign). 3. Ask the patient to close his eyes. Interpretation of the Fall correction is abnormal and is called a positive sign of Romberg. It's This. instability is caused by sensory ataxia (i.e. a deficiency of proprioceptive or vestibular function, rather than cerebellar function). Causes of proprioceptive dysfunction include joint hypermobility (e.g., Ehlers-Danlos syndrome), B12 deficiency, Parkinson's disease and aging (known as presbyproprie). Causes of vestibular dysfunction include vestibular neuritis and Meniere's disease. Swaying with correction is not a positive result and often occurs in cerebellar disease due to truncal ataxia. Speech Evaluation speech by asking the patient to repeat the following phrases: The British Constitution Baby hippopotamus Cerebellar lesions can cause attackism dysarthria, which can present in a number of ways: Scan speech (also known as staccato speech): words are broken down into separate syllables, often divided by pauses and spoken at different volumes. Slurred speech: patients are often mistaken for being intoxicated as a result. Scans and slurred speech often occur in combination (often referred to as slurred staccato speech). Nistagm Nystagm's eyes include repetitive, involuntary eye vibrations and can be either physiological (i.e. benign) or associated with cerebellar pathology. Assessment when assessing nystagmus. start by asking the patient to report any double vision (diplopia) if they experience it during the evaluation. Diplopia may suggest the presence of squint, which may be associated with some cerebellar syndromes (e.g. vestibulocebellar syndrome). 1. Ask the patient to look straight ahead and examine the eyes in the primary position. Look for any abnormal movements, such as nystagmus. 2. Ask the patient to keep his head in place and follow the finger (or other visual target) with his eyes. 3. Move your finger over different nesses of vision in the 'H' pattern. 4. Look for a few strikes of nystagma (a few strokes at the extremes of the view may be a normal option and called physiological nystagmus). Describing the nystagmus The discovery of the presence or absence of a nigmagma will suffice in the OSCE expertise, however, nystagmus can be described further by assessing the following: The direction of nystagmus: most nystagmus has a fast phase and a slow phase (the term spurt nystagmus). According to the convention, the direction of the nystagmus is determined by the direction of the fast phase. In cerebellar lesions, the direction is directed towards the lesion. View direction: Please note if nystagmus is present on a horizontal or vertical view. Nystagmus plane: pay attention if nystagmus is hitting a horizontal or vertical plane. Other eye impairments Other eye impairments that are associated with cerebellar disease include dysmetric saccades and impaired smooth pursuit. Dismetric saccades 1. Spread your hand about 30 cm to the side 2. Ask the patient to look at your hand and then return to the Nose. Repeat this assessment on both sides. The movement of the patient's eyes should be fast and accurate. In cerebellar lesions often there is an excess (i.e. the eyes go too far past the target, and then corrected back to the goal). This excess and subsequent correction are known as dysmetric saccades. Breaking Smooth Pursuit When the patient tracks your finger, the eyes should move smoothly (known as a smooth chase). In cerebellar lesions, the chase can be a jerk or saccadic (i.e. consists of hostesses of small movements). The upper limb finger-to-nose test Score finger-to-nose test is a convenient method of assessing upper limb coordination: 1. Position the finger so that the patient must fully reach out to reach it. 2. Ask the patient to touch the nose with the tip of his index finger and then touch the tip of his finger. 3. Ask the patient to continue doing this finger-to-nose movement as fast as they are able to. Interpretation When patients with cerebellar pathology perform this task they can exhibit both dysmetry and intentions of tremor: Dismetry: refers to the lack of coordination of movement. Clinically, this leads to the patient missing the target, over-fulfilling/shooting. Intention tremor: a wide, rough, low-frequency tremor that develops as the limb reaches the end point of deliberate movement. Clinically this leads to a tremor that becomes apparent as the patient's finger approaches yours. Be careful not to mistake the action tremor (which occurs throughout the movement) for the intention of tremor. The presence of dysmetry and tremor intentions leads to ipsylateral cerebellar pathology. The rebound phenomenon is a rebound reflex phenomenon that occurs when a patient tries to move a limb against resistance that has been suddenly removed. Score 1. Ask the patient to close his eyes and open his hands in front of him with his palms up. 2. Explain to the patient that you are going to apply some downward resistance on each hand and that they should try to maintain the current position of their hands as you apply this resistance. 3. Click down on one of the patient's forearms and then immediately remove the resistance. 4. Watch the movement of the assessed limb. Interpretation in healthy people, when resistance is removed limb, tend to move a short distance upwards (i.e. the direction the patient pushes to maintain the position of the limbs) before the antagonist muscles contract and move the limb back to its original position. It is a normal reflex that leads to a rebound phenomenon. An exaggerated version of the rebound phenomenon suggests spasticity (e.g., a stroke affecting the brain). The complete absence of the phenomenon caused by the inability of antagonistic muscles to contract is self-induced Disease. Score tone Score tone in muscle groups of the shoulder, elbow and wrist on each hand, comparing each side as you go: 1. Support the patient's hand by holding their hand and elbow. 2. Ask the patient to relax and allow you to fully control the movement of the hand. 3. Moving the muscle groups of the shoulder (circumcision), elbow (bending/expansion) and wrist (circumcision) through the entire spectrum of movements. 4. Feel the anomalies of tone when assessing each joint (e.g. hypotension). Interpretation of hypotonia can be caused by ipsyal cerebellar damage. However, the ability to

detect decreased muscle tone is highly subjective and in many cases, the tone may feel normal in cerebellar disease. As a result, it is advisable not to put too much weight on this sign or lack thereof. Dysdiadochokinesia Dysdiadochokinesia is a term that describes the inability to perform fast, alternating movements, which is a feature of ipsilateral cerebellar pathology. Score 1. Ask the patient to place the left palm on top of the right palm. 2. Then ask them to flip over their left hand and touch the back of the right palm. 3. Now ask them to return their left hand to their original position (left palm on the right palm). 4. Ask the patient now to repeat this sequence of movements as fast as they are able to until you tell them to stop. It is often helpful to demonstrate the sequence of movements to the patient to help understanding. 5. Observe the speed and fluency by which the patient can perform this sequence of rapidly alternating movements. Repeat the assessment from the other side. Interpreting patients with cerebellar ataxia may struggle to accomplish this task, with their movements appearing slowly and irregularly. The presence of dysdiadochokinesia indicates an ipsilateral cerebellar pathology. Lower limb tone Although the tone can be re-evaluated in the lower extremities, it is often not required in the cerebellar examination if you have already comprehensively appreciated the tone in the upper extremities. Score A brief assessment of the tone in the muscle groups of the hips, knees and ankles on each leg, comparing each side as you go: 1. With the patient lying on the examination couch, roll each leg to assess the tone in the muscles responsible for hip rotation. 2. Lift each knee quickly out of bed (warning the patient first) and observe the movement of the foot. In patients with a normal tone, the knee should grow while the heel remains in contact with the bed (the heel will usually remove the bed if there is an elevated tone). Interpretation of hypotonia can be caused by ipsilateral cerebellar damage. However, the ability to detect reduced muscle tone is highly subjective and in many cases, the tone may feel normal in the cerebellar As a result, it is advisable not to put too much weight on this sign or lack thereof. No. Evaluate the knee reflex (L3, L4) in each of the patient's lower limbs. Explain to the patient that you are now going to evaluate their reflexes by tapping gently on the leg with a tendon hammer (it is useful to show the patient the hammer tendon at this stage). For each of the reflexes, the patient's lower limb should be completely relaxed. Make sure to keep the tendon hammer handle at its end to allow gravity to help a good swing. If the reflex appears missing make sure the patient is completely relaxed and then perform a reinforcement maneuver by asking the patient to squeeze your teeth together while you simultaneously press the tendons. Score 1. Remove the weight from the patient's lower limb, either supporting it or asking the patient to hang his feet on the side of the bed. Make sure the patient's lower limb is completely relaxed before assessing the deep tendon reflex. 2. Click on the tendon patellar with a tendon hammer (making sure to hold the tendon hammer handle at its end to gravity to help a good swing). 3. If the reflex appears missing make sure the patient is completely relaxed and then perform a reinforcement maneuver. Interpreted in cerebellar disease, reflexes are described as hanging, which means less brisk and slower in their rise and fall. However, like a decrease in tone, this sign is very subjective and often reflexes seem normal in cerebellar disease. The heel-to-shin test Score heel-to-shin test is a convenient method of assessing lower limb coordination: 1. Ask the patient to place their left heel on their right knee and then run it down the shin in a straight line. 2. Then ask them to return the left heel to the starting position above the right knee. 3. Now ask them to repeat this sequence of movements in a smooth motion until you tell them to stop. 4. Repeat the right heel assessment on the left foot. Interpretation of dysmetria (i.e. inconsistencies) when trying to accomplish this task leads to ipsilateral cerebellar pathology. Caution note: weakness (e.g. from upper motor neurons) can also lead to obvious inconsistency of this movement. As a result, the power must be evaluated before any diagnostic conclusions are drawn. To complete the exam... Explain to the patient that the examination is complete. Thank you to the patient for the time. Wash your hands. Summarize your findings. Today I examined Mrs. Smith, a 64-year-old woman. On general examination, the patient looked comfortable at rest, with normal speech and without any other stigmatized cerebellar disease. There were no items or medical equipment around the bed. Gate was normal, and there was no evidence of nystagmus. Evaluation of limbs showed normal tone, reflexes and coordination. Thus, these findings with normal cerebellar cerebellar For completeness, I would like to conduct further assessments and investigations. Further Assessments and Research Reviewer Dr. Gemma Maxwell Neurology Registrar cerebellar function test pdf. cerebellar function test ppt. cerebellar function test physiology. cerebellar function test finger to nose. cerebellar function test heel to shin. cerebellar function test video. list and describe 3 tests of cerebellar function. cerebellar function is assessed by which of the following tests

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