cva - stroke - and terms Cheat Sheet

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assessments

NIH stroke scale	15 item evaluation for CVA on consciousness, language, neglect, visual fields, eye movement, motor strength, ataxia, dysarthria, and sensation. 0=No CVA, 21-42=-Severe CVA.
Mini FIM	Evaluation of function – self-care, transfers, mobility, and cognition. 0=Not taken place, 1= total assist, 7= independent. A score is obtained for each functional task. Includes 7 of the 18 items of the FIM.
FIM	being phased out and replaced with CARE Tool.
Glasgow coma scale	eye-opening, verbal response, and motor response. <3=veg-atative state, 3-8=severe disabi-lity, 13-15=mild injury.
barthel index	evaluation of function for eating, grooming, bathing, bowel and bladder, toileting, dressing, mobility, transfers, and stairs. 0-100. 0=total dependence, 100=total independence.
AM PAC 6	Measures the 3 functional domains of basic mobility, daily activities, and cognition.

assessments (cont)

assessment of motor and process skills AMPS	observation of ADLs in a natural environment.
modified ashworth scale	measures spasticity
activity card sort	clients describe their social, daily, and leisure activities.
canadian occupational performance measure COPM	captures client's self-p-erception of performance in self-care, productivity, and leisure.
community integration questionnaire	assesses limitations in social and community interactions
stroke impact scale	self-report questionnaire of disability and health-re-lated QoL
reintegration to normal living index	quantitatively assesses the degree that clients can reintegrate into social activities
montreal cognitive assessment MoCA	assesses for the level of cognitive impairment.

stroke tx considerations

type of occupation	problems	tx techniques
occup ations while seated	1. Loss of trunk and postural control 2. Inability to sit in proper alignment 3. Loss of righting and equili-brium reactions 4. Increased risk for falls -may fall during attempts at function 5. Dysfun-ction in limb control - difficulty reaching beyond arm span 6. Visual dysfun-ction secondary to head and neck misali-gnment 7. Symptoms of dysphagia due to misali-gnment 8. Impaired ability to interact with the enviro-nment 9. Decreased ADLs	1. Establish a neutral yet active starting alignment - feet flat on floor in weight bearing position -equal weight distribution through ischial tuberosities -neutral to slight anterior pelvic tilt -erect spine -head over shoulders and shoulders over hips 2. Establish the ability to maintain the trunk in midline using external cues. -mirror for visual feedback -verbal cues -environm-ental cues 3. Maintain trunk ROM through wheelchair and armchair positi-oning that maintains the trunk in proper alignment. - exercise program focused on trunk ROM -hands on facilitation as needed for mobili-zation 4. Dynamic weight shifting activities to allow practice of weight shift through the pelvis. -set up occupations to reach beyond arm span and limits of stability -adjust posture.. 5. Trunk strengthening -use tasks that require the patient to control the trunk against gravity - bridge the hips in supine position to strengthen the back

extensors 6. Compensatory strategies and environmental adaptations -use when trunk control does not improve to a sufficient level, putting patient at risk -compensatory strategies such as one-handed shoe tying -adaptive equipment, including reachers and long handled devices -wheelchair seating systems -lumbar rolls -lateral supports -cushions

stroke tx considerations (cont)

occupations while standing	1. Asymmetrical weight distribution - weight distribution is seen through the lower extremities as well as the trunk .. 2. Automatic postural controls may be impaired. -ankle strategies, used to maintain center of mass and control small, slow, swaying motions -hip strategies, used to maintain or restore equilibrium - stepping strategies, used when ankle and hip strategies are ineffective .. 3. Resulting problems with base of support (BOS) - movement of BOS toward the COM - steps taken to widen BOS	1. Establish symmetrical BOS and proper alignment to prepare to engage in occupations - hands on support as needed -feet approximately hip width apart - equal weight bearing through feet -neutral pelvis -knees slightly bent - aligned and symmetrical trunk .. 2. Focus on ability to bear weight and shift weight through affected lower extremity. .. 3. Encourage dynamic reaching activities in multiple environments to develop task specific weight shifting abilities .. 4. Use the environment to grade task difficulty and provide external support5. Train upright control within the context of functional tasks

stroke tx considerations (cont)

inability to use language	Aphasia – a language disorder that results from neurological impairment Global aphasia – loss of all language skills Broca's Aphasia – expressive aphasia, results from damage to the frontal regions of the left hemisphere Wernicke's Aphasia – receptive aphasia, results in the inability to understand language in both spoken and written forms Anomic aphasia – difficulty with word retrieval	1. Give the patient time to respond – do not force a response .. 2. Use concise language and simple sentences .. 3. Insure generalization, or transfer of learning from one context to another -vary treatment environments -vary the nature of tasks - help patient to become aware of how he or she processes information - teach processing strategies -relate new learning to old .. 4. Types of transfer i. Near transfer – involves transfer of learning between two tasks with one or two different characteristics iii. Far transfer – involves transfer of learning between tasks that are conceptually similar but few or no characteristics in common iv. Very far transfer– spontaneous application of learning to everyday living

stroke tx considerations (cont)

inability to use UE	1. Limitations due to: -pain -contracture -loss of motor control - weakness - learned disuse .. 2. Subluxation:- malalignment of the shoulder caused by instability of the glenohumeral joint - common complication of CVA - inferior subluxation – head of the humerus slides below the glenoid fossa – caused by muscle weakness and atrophy - anterior subluxation – head of the humerus sits anterior to the glenoid fossa – caused by weak rotator cuff musculature and muscle spasticity -superior subluxation – head of the humerus lodges under the acromion process and the coracoacromial ligament – also called high riding shoulder … 3. Tonicity: -low muscle tone immediately following CVA - glenohumeral joint and wrist are susceptible to damage due to subluxation and unstable wrist - splinting used to maintain joint	1. Evaluation should focus on assessing the patient's ability to integrate UE performance of functional tasks -use the affected UE to support performance … 2. Standardized assessments include TEMPA, AMAT, Jebsen, AMPS … 3. Weight bearing through affected UE … 4. Moving objects across a work surface with a static grasp - ironing, opening drawers, polishing furniture … 5. Reaching and manipulation -reach for and hold object - manipulate the object with thumb and finger movements -use objects of different

	alignment, protect tissues from changes in length, prevent injury, and assist with edema control -resting hand position to provide support to the palmar arch while maintaining neutral wrist position -high muscle tone may develop several days or weeks after CVA, resulting in limited movement and/or contracture of the affected arm	sizes and shapes to facilitate hand control during reach and manipulation - choose activities appropriate for motor control level and grade tasks … 6. Constraint-induced movement therapy (CIMT) - restrain the unaffected arm to force movement of the affected arm … 7. Train the arm to be used in weight bearing while reaching

areas of the brain

frontal lobe	
motor control	premotor cortex
problem solving	prefrontal area
speech production	BROCAs area
temporal lobe	
auditory processing	hearing
language comprehension	wernickes area
memory	information retrieval
brainstem	involuntary responses
parietal lobe	
touch perception	somatosensory cortex
body orientation	sensory discrimination
occipital lobe	
sight	visual cortex
visual reception	visual interpretation
cerebellum	balance and coordination

stroke terminology

accommodation	eyes ability to adjust to various distances in the environment
acuity	visual sharpness
adaptation	coping with the changes of task demands
adhesive capsulitiis	frozen shoulder
adjustment to disability	psychosocial condition in which the pt faces barriers to the acceptance of their disability
agraphia	acquired writing disturbance

stroke terminology (cont)

anarthria	speech impairment resulting in the absence of speech
ankle strategy	autonomic postural responses to maintain balance using the ankles
anomia	inability to name things
anosognosia	poor insight or denial of one's own disabilities
aphasia	communication deficit resulting in the loss of the ability to speak or understand language
aprosody	difficulty expressing and recognizing social emotions
astereognosis	the inability to recognize things using touch; tactile agnosia
blocked practice	practice using drills with numerous reps
broca's aphasia	non fluent expression affecting speech
cognitive orientation to daily occupational performance model	a client centered meta cognitive approach with collaboration, goal setting, performance analysis, cognitive strategies, guided discovery to promote generalize and transfer
color agnosia	inability to name or recognize colors
concrete thinking	inflexible thinking

stroke terminology (cont)

confrontation	movement of an object through the clients visual field
convergence	coordinated eye movement inwards to focus on an object
cortical blindness	blindness resulting from a lesson in the cerebral cortex
dissociation	separation of body parts during movement patterns
divergence	eye movement outwards
environmental control unit	a device used to interact with the environment
far transfer	introducing an activity of the same context but different from the initial task performed
global aphasia	severely impaired language
hemianopsia	visual field deficit (blindness) in half of the visual field
heterotopic ossification	overgrowth or deposit of bone in soft tissues which may affect movement
hyperopia	farsightedness
ideational apraxia	inability to perform a task due to loss of a model or mental representation of the procedure

stroke terminology (cont)	
interm-ediate transfer	changing a number of task parameters while keeping familiar initial task parameters
ipsilateral pushing	stroke syndrome characterized by physically pushing the body towards one side due to mispercevied center of gravity and midline
learned nonuse	lack of use of a body part resulting from stroke and its diminished perception of function
motor adaptation	ability to adapt to postural responses to environmental demands and task changes
motor apraxia	inability to perform purposeful movements due to impaired planning and sequencing of movements
myopia	nearsightedness
near transfer	performing an alternate form of the initial task
neoplasm	abnormal tissue growth, tumor
organi-zation	ability to organize thoughts to perform a task in an organized manner with proper sequencing and timing
praxis	ideation, planning purposeful movements

stroke terminology (cont)	
procedural memory	recalling the steps of a task
prosop-agnosia	inability to recognize familiar faces
saccadic eye movements	fast, voluntary, coordinated movements of the eyes to fixate back and fourth on two points at a distance
somato-agnosia	body scheme disorder characterized by decreased awareness of body structure and recognition of ones own body parts and their relati-onship to each other
spasticity	hypertonus and hyperactive stretch reflexes
strabismus	inability of eyes to cross axes due to imbalanced eye muscles, impaired saccades
trende-lenberg sign	when one stands on the affected limb and the opposite gluteal fold falls
unilateral body neglect	forgetting about one side of the body due to stroke
wallenberg sign	horner syndrome, cerebeller ataxia and contralateral loss of pain and temp
wernickies aphasia	reduced speech compre-hension

symptoms associated with parts of the brain	
internal carotid artery	1. Contralateral hemiplegia, hemianesthesia. And homonymous Hemianopsia 2. Occurrence in dominant hemisphere is associated with aphasia, agraphia/dysgraphia, acalculia/dyscalculia, right/left confusion, finger agnosia 3. Occurrence in non-dominant hemisphere associated with perceptual dysfunction, unilateral neglect, anosognosia attention deficits, loss of topogr-aphic memory
middle cerebral artery - most common	1. Contralateral hemiplegia with greater involvement of the arm, face and tongue; sensory deficits; contralateral homonymous hemianopsia and aphasia if the lesion is in the dominant hemisphere 2. Pronounced deviation of the head and neck toward the side of the lesion 3. Perceptual deficits such as anosognosia, unilateral neglect, impaired vertical perception, visual spatial deficits

symptoms associated with parts of the brain (cont)	
anterior cerebral artery	1. Contralateral lower extremity weakness, more severe than upper extremity weakness. 2. Apraxia, mental changes, primitive reflexes and bowel/-bladder incontinence may be present. 3. Cortical sensory loss in lower extremity. 4. Intellectual changes including confusion, disorientation, whispering, slow processing speed, distractibility, limited verbalizations, amnesia 5. Total occlusion of artery results in contralateral hemiplegia with severe weakness of the face, tongue and proximal arm muscles, marked spastic paralysis of the distal lower extremity.
posterior cerebral artery	1. Broad, multiple symptoms 2. Sensory motor deficits, involuntary movement disorders, postural tremors, hemiataxia, memory loss, astereognosis, dysesthesia, kinesthesia, contralateral homonymous hemianopsia, anomia, topographic disorientation, visual agnosia

symptoms associated with parts of the brain (cont)	
cerebellar arteries	1. Ipsilateral ataxia, contralateral loss of sensation of pain and temperature 2. Ipsilateral facial analgesia 3. Dysphagia, dysarthria, nystagmus and contralateral hemiparesis