Unified multiple system atrophy rating scale pdf

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Part II-13) 0. Normal. 1. Minor body impact and/or retropulasia with unarmed recovery. 2. Moderate body effect and/or insufficient postural response; could fall if the expert is not caught. 3. Severe body influence. Very unstable. Aims to lose balance spontaneously. 4. It is impossible to stand unaided.
JMSARS Unified Multiple System Atrophy Rating Scale, SARA Scale for the Assessment and Rating of Ataxia, BBS Berg Balance Scale The European Multiple System Atrophy-Study Group (EMSA-SG). Geser F, Seppi K, Stumpfer-Kunchev M, Koellensperger M, Diem A, Ndayisaba J., Ostergaard K, DuPont E, Carolle B, Marie M, Sepreg A, Hagler J, Mileson GE, Lindvell G, Shimke M, Sepreg A, Hagler J, Mileson GE, Lindvell G, Shimke M, Sepreg A, Hagler J, Mileson GE, Lindvell G, Shimke M, Sepreg A, Hagler J, Marie M, Marie M, Marie M, Marie M, Marie M, M
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29. J Neuron Transm (Vienna). 2005. PMID: 16049636 Review. 1 Section of Neurology, Innsbruck Medical University, Innsbruck, AustriaFind articles Florian Krismer 1 Department of Neurology, Innsbruck Medical University, Innsbruck, AustriaFind articles Florian Krismer 1 Department of Neurology, Innsbruck Medical University, Innsbruck, AustriaFind articles Florian Krismer 1 Department of Neurology, Innsbruck Medical University, Innsbruck, AustriaFind articles Florian Krismer 1 Department of Neurology, Innsbruck Medical University, Innsbruck, AustriaFind articles Florian Krismer 1 Department of Neurology, Innsbruck Medical University, Innsbruck Medical University
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Sapienza, Rome, Italy 9 Neurology, Center for Biomedical Research, University of Biomedical Research, Ulm Author: Professor Gregor K. Wenning MD PHD MSC, Department of Neurology and Ne
No43) (0512) 504 81811 Unified Scale multiple atrophy rating system was developed to provide a surrogate measure of disease progression in multiple atrophy system. This study determined the intra-party coordination of the part of auto analysis of a single multiple system atrophic rating scale. All patients were first
examined face-to-face, while video recordings, two senior and two junior investigators. Videos of patient examinations were re-evaluated after 3 months. The reliability of the intrarater for each element was analyzed by kappa statistics. The overall weighted values were at least substantial or excellent for all unified multiprophys of all elements of the evaluation of multiple atrophy system, except for eye motor dysfunction, which showed only moderate intrarater was comparable between senior and junior tariffers with all differences in \leq 0.22. Motor examination part of a single multi-profile system
atrophy of the rating scale was found to be satisfactory reliability of the intratratra in the current cohort. Keywords: Multiple system atrophy (MSA) is a relentlessly progressive and ultimately fatal neurodegenerative disease characterized by clinically
regetative failure, accompanied by characteristic motor characteristics.1, 2 In accordance with applicable diagnostic criteria, two motor variants can be identified; patients with predominant Parkinson's are labeled MSA-P, while MSA-C is applied to patients with an outstanding cerebellar phenotype.3 In addition, three
liagnostic categories of increasing certainty have been identified: possible, probable and defined MSA. Although certain MSA requires pathological confirmation of widely glial cytoplasmic inclusions accompanied by a clear neurodegeneration, 4 possible and probable MSA to rely on clinical and and Patient care is
currently limited to symptom-based therapy due to the lack of currently disease-altering agents. The European MSA Research Group (EMSA-SG) has recognized the need for a tool to assess specific diseases that can serve as an indicator of outcome in clinical trials, and thus reliably determine the effectiveness of
hese interventions. That's why we developed and approved the SINGLE MSA Rating Scale (UMSARS).6 During the verification process, IT was shown that UMSARS is a fairly short, multidimensional, reliable and valid scale for the semi-narcotic evaluation of Caucasian patients with MSA with high internal consistency and essential to excellent intertrat agreement.6 Subsequently, two independent teams confirmed the sensitivity of the instrument to change 7, 8, which enabled multicenter clinical trials using UMSARS as a surrogate measure of disease progression.9 10 We here report on the reliability of the intrarater motor examination
part of UMSARS, as defined in the multicenter inspection study. A total of 40 patients clinically diagnosed with MSA according to the original Gilman11 criteria were recruited at four EMSA-SG centers (Bordeaux, Innsbruck, London, Toulouse) and evaluated for their regular medications. The global severity of the disease
vas determined by Hoehn and Yahr (H'Y) and the 3-point severity scale of the disease (SS-3.6 Intrarater was tested in a two-step approach. First, all patients were examined face-to-face (live rating) by one senior investigator traveling to the centres (GKW), as well as additional senior and two junior investigators from
each local centre (local fare teams were Bordeaux: FT (senior), IG (junior), FY (junior); Innsbruck: WP (senior), KS (junior), Toulouse: OR Senior, MG Junior, FO Junior, FO Junior). Council-certified neurologists with long-term experience in motion disorders were
considered senior investigators, while the term junior researchers applied to residents in neurology. Each eye-to-face exam was recorded on videotape. In the second stage, three months after the initial examination, the same investigators reclassified the motor part of the UMSARS examination on the original video
ecordings. In order to obtain independent assessments, experts were not allowed to exchange views during the assessments. Finally, since rigidity cannot be judged by inspection, paragraph 6 of the UMSARS (Enhanced Tone) auto inspection subsc up has been excluded from this analysis. The data was analyzed using SPSS 20.0 (SPPS Inc., Chicago, IL, USA) and Excel (Microsoft, Redmond, WA, USA). Reliability intrarater among individual junior and senior tariffs, as well as general agreement on each item umSARS were determined by kappa statistics (12, 13 Weighted values were calculated using the help of Disagreement
scales14 and is interpreted as follows in accordance with recommendations published earlier:15 0 to 0.20 small agreement; 0.21 to 0.40 fair agreement; 0.81 to 1.00 excellent agreement. The intra-strata arrangement for the UMSARS live autoanalysis
and video rating was determined using intra-class correlation ratios (ICC) derived from the analysis of random effects in one side of the variance model.16 In this cohort MSA-P was more frequent, than MSA-C (MSA-P:MSA-C 1.8:1) with diagnostic certainty, which was considered probable in 32 cases and possible in 8
out of 40 cases. Average (standard deviation) age when symptoms appear and duration of the disease is 57.0 (8.5) and 6.0 (4.2) years, respectively. Further demography and Clinical CharacteristicsPatents (n)40Gender (male/female, (n)16/24MSA-P/C (n)26/14MSA-P/C (n)26/14M
possible/probable (n)8/32Age at the beginning, years (average duration ± SD)57.0 ± duration 8.5Disease, years (average ± SD)6.0 ± 4.2H and Y stage, median (range)4 (2 - 5)3-point gravity scale (n)5/13/22UMSARS (average ± SD, median, I'R)52.3 ± 18.3, 53.5, 31.0UMSARS ADL (average ± SD, median, I'R) 25.8 ± 18.5 (average ± SD, median, I'R) 25.8 ± 18.5 (average ± SD, median, I'R) 26.5 ± 18.5 (average ± SD, median, I'R) 27.5 ± 18.5 (average ± SD, median, I'R) 27.5 ± 18.5 (average ± SD, median, I'R) 28.8 ± 18.5 (average ± SD, median, I'R) 28.8 ± 18.5 (average ± SD, median, I'R) 27.5 ± 18.5 (average ± SD, median, I'R) 28.8 ± 18.5 (average ± SD,
0.6, 25.0, 16.0UMSARS ME (average ± SD, median, I'R)26.5 ± 9.6, 25.5, 13.5 Intrarat reliability analysis results are summarized in Table 2. The overall weighted values were at least substantial (I) and 0.6-0.8) or excellent (Japanese ≥ 0.8) for all UMSARS auto-examination items, except for eye motor dysfunction, which showed a moderate intrarater agreement. The reliability of intrarater was comparable between senior and junior fares with all differences in ≤ 0.22. Finally, intra-class correlation of motor expertise UMSARS is reliable. UMSARS Motor Examination: Intrarater Reliability. In (w) over
all centers; 0-0.20, small agreement; 0.21- 0.40, fair agreement; 0.41-0.60, moderate agreement; 0.61-0.80, substantial agreement; 0.81-1.00, great agreement; 0.81-1.00,
5 Action tremor0.820.690.76 6 Elevated toneNo applicable 7 Fast alternating hand movement0.680.600.64 8 Finger tapping0.780.740.740.76 9 Leg agility0.800.600.7110 Heel-Sheen test0.840.820.8311 Coming from the chair0.960.970.9612 Posture0.860.840.8513 Body sway0.9 UMSARS II - 1st exam0.980.970.98It
nas previously been demonstrated that UMSARS is an MSA-specific semi-college assessment tool, showing a high internal sequence, as well as a substantial South Africa. In addition, two independent groups have shown that UMSARS scores are sensitive to changes. 7, 8 To complete the verification process scale, we
eport here on the results of the intratrater test study. The umSARS auto-review part underwent intra-party reliability testing, comparing the live rating with the subsequent video analysis of the initial exam 3 months later. Our results showed that all but one item (eye dysfunction of the engine) were essential to the excellent intrarater agreement. The dysfunction of the eye motor showed moderate agreement, which can be explained by the problem of scoring eye movements through video analysis. As expected, values and values were higher in the intrarater reliability study compared to the interrater reliability study published
earlier.6 In addition, the intratratra agreement was comparable between senior and junior examiners with differences in values that were lower or equal to 0.20, excluding paragraph 3 (eye motor dysfunction), which had 0.22 euros. The latter observation confirms the previous finding that junior researchers can use
JMSARS reliably once they are trained to use UMSARS and provided they receive detailed instructions.6 This study once again emphasizes that UMSARS has satisfactory reliability of intrarater as a specific disease and a multidimensional rating tool for semi-commic assessment of patients with SLA. However, some
estrictions must be recognized. Video analysis can't perfectly replicate face-to-face expertise. An intraratic study with two live exams separated by a certain time interval is difficult to perform in MSA. The choice of the appropriate time interval between the two live examinations is limited by the rapidly progressing course of MSARS and several UMSARS items for follow-up. On the other hand, a brief follow-up examination between two potential
ive exams could lead to a bias towards overestimating the reliability of the intrarater. So we chose this video recording study design for face-to-face patient surveys followed by a reassessment using the same video 3 months later. Moreover, since the scale has been confirmed in European Caucasian countries, its
validity and applicability in other racial or ethnic contexts have yet to be established. Finally, UMSARS does not cover all aspects of complex MSA phenomenology, so other tested scales may need to be developed to document a more complete picture of the disease. We would like to thank all patients and families, as
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Quinn1a, 1b, 1c, 2c, 3bWerner Poewe1a, 1b, 1c, 2a, 2c, 3bGregor K. Wenning1a, 1b, 1c, 2a, 2c, 3bFinancial DisclosuresFlorian Krismer Stock Ownership in medically-related fieldsNoneIntellectual Property RightsNoneConsultanciesNoneExpert TestimonyNoneAdvisory BoardsNoneEmploymentDivision of Neurobiology, Department of Neurology, Innsbruck Medical UniversityPartnershipsNoneContractsNoneHonorariaNoneRoyaltiesNoneGrantsNoneIntellectual Property RightsNoneConsultanciesNovartis, Boehringer Ingelheim, Lundbeck, Schwarz Pharma, UCB,
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