Field Testing of an Ataxia Scoring and Staging System

EMMANUELLE POURCHER and ANDRÉ BARBEAU

SUMMARY: The authors present a simple system for disability scoring and functional staging of an ataxic patient, based on modifications of a previous scheme advocated by De Falco and collaborators (1979). This system was tested under field conditions in 47 ataxic subjects and found to be useful and functional.

SUBJECTS AND METHODS

During a two week period in the month of July 1980, on the occasion of our yearly field investigation of ataxic patients, a total of 47 subjects (26 men; 21 women) were studied by a team of two neurologists (E.P. and A.B.). The type of ataxies involved are listed in Table One. Four patients had all the symptoms of typical Friedreich's ataxia as described by Geoffroy et al (1976). Three suffered from what we have termed “Ataxia of Beauce” (Barbeau, 1980). These patients had a recessive disorder characterized by gait and truncal ataxia with pyramidal tract deficits and no signs of posterior column involvement. It will be noted that, until the biochemical marker is known, we have elected to assign geographic names to the phenotypic subtypes examined. This takes into account the genetic and geographic isolate factors often encountered. Two patients had olivo-cerebellar atrophies (OPCA) of a recessive type, mainly characterized by speech disorders and gait ataxia (so called Matane type). Twenty patients suffered from a dominant form of olivo-ponto-cerebellar atrophy found in the Gaspé peninsula and previously reported by us (Wasliaux et al, 1978). The other 18 patients were examined in Minneapolis through the courtesy of Dr. Larry Schut, during a yearly follow up clinic of the National Ataxia Foundation. They included one female patient with the Sanger-Brown variant of OPCA (spasticity and macular degeneration), two OPCA type I (Konigsmark and Weiner, 1970) from Wyoming and 15 members of the well known Schut-Swier OPCA family (Schut 1950, Landis et al, 1974) including 5 asymptomatic at risk subjects, and 10 clear-cut ataxics.

All patients were examined at home (or at the Minneapolis Clinic) by the two neurologists working as a team. While one carried out a standard neurological examination, the other one qualified every symptom and sign on a 0 to 3 scale (0 = normal, 1 = slight; 2 = moderate and 3 = severe disability) and simultaneously with the scale reported by De Falco et al (1979). Both neurologists then decided on the functional stage to ascribe to each patient based on a scheme modified from De Falco et al (1979) and listed in Table 2.

RESULTS AND DISCUSSION

All 47 patients kindly collaborated in this detailed examination procedure. The initial evaluation of the data was based on the exact reproduction of the scheme developed by the Italian authors. This scheme lists 26 scored items. It proved to be adequate, as can be seen in the paper by Campanella et al in this issue, but incomplete and not...
there was a significant positive corre­
graded and the averaged results are
The 47 patients in our study were thus
clinician: slight, moderate and severe
scale of 0 - 3 which is probably the one
noted that all scores are graded on a
on a 0 - 4 scale,
We plan to use this scheme in a series
in the diagnosis of certain forms of
ataxia are not included, such as muscle
strength, pes cavus, scoliosis, postural
tremor. We were forced to add copious
notes to the recording sheets to reflect
the complete picture.
For all these reasons we decided to
prepare a new standardized grading
form (Tables 3 and 4) which permits a
discriminant analysis of major sub-
scores: cranial nerves, coordination,
tone, reflexes, peripheral signs and
muscle strength. Criteria and defini-
tions are listed in Table 5. It should be
noted that all scores are graded on a
scale of 0 - 3 which is probably the one
offering the most familiarity to the
clinician: slight, moderate and severe
disability or deviation from normal.
We feel that this scoring and staging
system is an easy, workable and
reproducible scheme for objectively
grading the disability of an ataxic
patient, even under field conditions.
We plan to use this scheme in a series
of pharmacologic trials to be under-
taken shortly.
ACKNOWLEDGMENTS
These studies were made possible by a grant from
"l'Association Canadienne de l'Ataxie de Friedreich".
The authors would particularly like to thank Dr. Larry
Schut and the National Ataxia Foundation of
Quebec for their generous hospitality and
coopera­tion.

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and complement typing in olivo-ponto-
cerebellar atrophy. Can. J. Neurol. Sci. 5: 75-
81.

TABLE 1
List of Patients Examined

<table>
<thead>
<tr>
<th>Type of Ataxia</th>
<th>Subjects Examined</th>
<th>Genes is</th>
<th>Ethnic Origin</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Friedrich's Ataxia</td>
<td>4</td>
<td>Recessive</td>
<td>French Canadian</td>
</tr>
<tr>
<td>2. Ataxia of Beauce</td>
<td>3</td>
<td>Recessive</td>
<td>French Canadian</td>
</tr>
<tr>
<td>3. Sanger-Brown cerebellar atrophy</td>
<td>1</td>
<td>Dominant</td>
<td>Scandinavian</td>
</tr>
<tr>
<td>4. O.P.C.A. (Wyoming type)</td>
<td>2</td>
<td>Dominant</td>
<td>Anglo-Saxon</td>
</tr>
<tr>
<td>5. O.P.C.A. (Matane type)</td>
<td>2</td>
<td>Recessive</td>
<td>French Canadian</td>
</tr>
<tr>
<td>6. O.P.C.A. (Schut-Swie r type)</td>
<td>5</td>
<td>Dominant</td>
<td>Dutch</td>
</tr>
<tr>
<td>7. O.P.C.A. (Gaspésie type)</td>
<td>10</td>
<td>Dominant</td>
<td>French Canadian</td>
</tr>
<tr>
<td>TOTAL</td>
<td>47</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TABLE 2
Functional Staging of Ataxia

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAGE 0</td>
<td>Normal in at-risk subject.</td>
</tr>
<tr>
<td>STAGE I</td>
<td>Patient with minimal signs detected during family screening, but previously undetected and unsuspected by patient.</td>
</tr>
<tr>
<td>STAGE II</td>
<td>Symptoms present, recognized by patient, but still mild. The patient is physically capable of leading an independent life, but work activities can be somewhat restricted.</td>
</tr>
<tr>
<td>STAGE III</td>
<td>Symptoms are completely developed. The patient needs help or aids to move about and transfer.</td>
</tr>
<tr>
<td>STAGE IV</td>
<td>Patient is confined to wheelchair.</td>
</tr>
<tr>
<td>STAGE V</td>
<td>Patient is confined to bed.</td>
</tr>
</tbody>
</table>

sufficiently discriminative. For example, some items are scored on a 0 - 2 scale, and others on a 0 - 4 scale, making it difficult to function in the field, without the criteria master sheet. Moreover, some items of importance in the diagnosis of certain forms of ataxia are not included, such as muscle strength, pes cavus, scoliosis, postural tremor. We were forced to add copious notes to the recording sheets to reflect the complete picture.

For all these reasons we decided to prepare a new standardized grading form (Tables 3 and 4) which permits a discriminant analysis of major sub-scores: cranial nerves, coordination, tone, reflexes, peripheral signs and muscle strength. Criteria and definitions are listed in Table 5. It should be noted that all scores are graded on a scale of 0 - 3 which is probably the one offering the most familiarity to the clinician: slight, moderate and severe disability or deviation from normal. The 47 patients in our study were thus graded and the averaged results are given in Table 6. It can be seen that there was a significant positive correlation between the total ataxia score and functional stages. A more detailed analysis of each sub-score (not reported here for lack of space but to be included in a thesis by E.P.) would reveal for example that OPCA patients have high coordination and tone scores while Friedreich's ataxia patients have very high ataxia scores coupled with maximal deviation from normal (decrease) in the tendon reflex score, severe muscle weakness scores (Table 7), and marked peripheral signs scores.


Ataxia Scoring and Staging

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TABLE 3
Ataxia Clinical Rating Scale

A. IDENTIFICATION
Name: ____________________________ Date exam: ____________________________
Address: __________________________ Examiner: ____________________________
Treating physician: __________________________ Chart No.: __________________________

B. EVOLUTION
Present age: ____________ Known heredity: ____________
Age at onset of symptoms: ____________ Handedness: ____________
Sex: ____________

C. DIAGRAM OF SPIRAL
(right and left hand)

D. SUB-SCORES
FUNCTIONAL STAGE

<table>
<thead>
<tr>
<th>Heredity</th>
<th>Age Onset</th>
<th>Duration illness (years)</th>
<th>Cranial nerves</th>
<th>Ataxia</th>
<th>Tone</th>
<th>Reflexes</th>
<th>Peripheral</th>
<th>Muscle str.</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+/-</td>
<td>+/-</td>
<td></td>
<td></td>
<td>MAX.138</td>
</tr>
</tbody>
</table>

E. CODING

F. FINAL DIAGNOSIS

TABLE 4
Ataxia Clinical Rating Scale

All items on 0 - 3 scale: 0: N; 1: Mild; 2: Moderate; 3: Severe disability

<table>
<thead>
<tr>
<th>Items</th>
<th>Score</th>
<th>Items</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. CRANIAL NERVES</td>
<td></td>
<td>B. COORDINATION</td>
<td></td>
</tr>
<tr>
<td>1. Speech</td>
<td></td>
<td>7. Normal gait</td>
<td></td>
</tr>
<tr>
<td>2. Nystagmus</td>
<td></td>
<td>8. Tandem gait</td>
<td></td>
</tr>
<tr>
<td>3. Eye movements</td>
<td></td>
<td>9. Romberg</td>
<td></td>
</tr>
<tr>
<td>4. Fundi</td>
<td></td>
<td>10. Finger to nose — right</td>
<td></td>
</tr>
<tr>
<td>5. Tongue changes</td>
<td></td>
<td>11. Finger to nose — left</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Items</th>
<th>Score</th>
<th>Items</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Spiral — right</td>
<td></td>
<td>15. Spiral — left</td>
<td></td>
</tr>
<tr>
<td>16. Adiadocokinesia — right</td>
<td></td>
<td>17. Adiadocokinesia — left</td>
<td></td>
</tr>
<tr>
<td>20. Postural tremor</td>
<td>SUB-SCORE (AT) MAX 42</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
C. TONE (deviation from N.)  
21. Tone — right arm  
22. Tone — left arm  
23. Tone — right leg  
24. Tone — left leg  
25. Holmes test — right  
26. Holmes test — left  

SUB-SCORE (T) MAX 18

D. REFLEXES (deviation from N.)  
27. DTR — right biceps  
28. DTR — left biceps  
29. DTR — right knee  
30. DTR — left knee  
31. DTR — right achil.  
32. DTR — left achil.  
33. Babinski — right  
34. Babinski — left  

SUB-SCORE (R) MAX 24

E. PERIPHERAL SIGNS  
35. Atrophy upper limbs  
36. Atrophy lower limbs  
37. Fasciculations  
38. Myoclonias  
39. Pes cavus  
40. Scoliosis  
41. Vibrations — right (secs)  
42. Vibrations — left (secs)  

SUB-SCORE (P.S.) MAX 24

F. MUSCLE STRENGTH DECREASE  
43. Right arm  
44. Left arm  
45. Right leg  
46. Left leg  

SUB-SCORE (MS) MAX 12

### TABLE 5  
Ataxia Clinical Rating Scale Criteria and Definitions

**GENERAL NOTES:** Unless otherwise indicated, all items are coded on a 0 to 3 scale where  
0: normal  
1: mild disability or deviation from normal  
2: moderate disability or deviation from normal  
3: severe disability or deviation from normal

**SPECIFIC CRITERIA** (Number corresponds to item; items not quoted, see above):

<table>
<thead>
<tr>
<th>Item</th>
<th>Title</th>
<th>Grades</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>NYSTAGMUS</td>
<td>1. fine lateral nystagmus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. clear lateral +/- upward gaze nystagmus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. spontaneous nystagmus</td>
</tr>
<tr>
<td>3.</td>
<td>EYE MOVEMENTS</td>
<td>1. smooth but slow pursuit (viscosity)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. saccadic or irregular pursuit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. paralysis in one or more directions</td>
</tr>
<tr>
<td>4.</td>
<td>FUNDI</td>
<td>1. slight temporal palor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. retinitis +/- optic atrophy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. macular or retinal degeneration + optic atrophy</td>
</tr>
<tr>
<td>5.</td>
<td>TONGUE</td>
<td>1. fasciculations alone</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. fasciculations + slight atrophy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. marked atrophy + limitation movements</td>
</tr>
<tr>
<td>6.</td>
<td>COUGH</td>
<td>1. hesitation in 3 consecutive coughs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. dyspnea and arrest in consc. coughs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. unable to do test</td>
</tr>
</tbody>
</table>
7, 8  NORMAL GAIT/TANDEM  1. dysbalance but gait without support
2. dysbalance but needs support
3. gait or tandem impossible

9.  ROMBERG  1. some oscillations eyes closed
2. oscillations eyes open
3. manoeuvre impossible

16, 17.  "TEST DES MARIONETTES"  1. fine hand tremor (extended arm)
2. marked hand tremor
3. hand, trunk and hand tremor

20.  POSTURAL TREMOR  1. gait or tandem impossible

D.  TONE & REFLEXES  To be scored as deviation from normal (mild, moderate, severe) with direction indicated: increased: +; decreased: -; (absent is scored as -3; presence of clonus implies +3)

25, 26.  HOLMES TEST  0. normal braking
1. braking present but delayed
2. arms hits examiner's protecting arm
3. arm would slap face or thorax without protection

33, 34.  BABINSKI TEST  1. no response to test (indifferent)
2. fanning of toes alone
3. fanning and slow big toe retraction

37.  FASCICULATIONS  1. rare fasciculations
2. localized but frequent fasciculations
3. generalized fasciculations

38.  MYOCLONIAS  1. rare myoclonias, unilateral
2. myoclonias bilateral, occasional
3. continuous myoclonias

39.  FEET  1. high arches
2. definite pes cavus
3. pes cavus + toe deformities

40.  SCOLIOSIS  1. scoliosis 0 - 10°
2. scoliosis 10 - 30°
3. scoliosis > 30°

41, 42.  VIBRATIONS  Taken with 128 cps tuning-fork at external malleolus
0. 11 or more secs
1. 8 - 11 secs
2. 5 - 8 secs
3. < 5 secs

43, 44, 45, 46.  MUSCLE STRENGTH  1. weakness upon testing only
2. difficulty in maintaining posture or resisting a pull
3. total paralysis

### TABLE 6

<table>
<thead>
<tr>
<th>Functional Stage</th>
<th>n</th>
<th>Mean Total Score</th>
<th>± S.E.M.</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 (at risk)</td>
<td>5</td>
<td>4.4</td>
<td>1.2</td>
<td>0 - 7</td>
</tr>
<tr>
<td>1</td>
<td>7</td>
<td>13.0</td>
<td>1.2</td>
<td>9 - 17</td>
</tr>
<tr>
<td>2</td>
<td>13</td>
<td>41.0</td>
<td>1.9</td>
<td>31 - 54</td>
</tr>
<tr>
<td>3</td>
<td>11</td>
<td>67.9</td>
<td>3.8</td>
<td>51 - 88</td>
</tr>
<tr>
<td>4</td>
<td>11</td>
<td>84.1</td>
<td>4.9</td>
<td>54 - 107</td>
</tr>
<tr>
<td>No. of ataxic patients</td>
<td>OPCA (Gaspé)</td>
<td>OPCA (Minn.)</td>
<td>Friedreich's</td>
<td>Beauce</td>
</tr>
<tr>
<td>------------------------</td>
<td>--------------</td>
<td>--------------</td>
<td>--------------</td>
<td>--------</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>10</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>mean age of onset</td>
<td>30.1 ± 3.1</td>
<td>20.6 ± 1.7</td>
<td>15.7 ± 0.9</td>
<td>17.7 ± 3.8</td>
</tr>
<tr>
<td>duration of illness (yrs)</td>
<td>13.6 ± 2.1</td>
<td>3.2 ± 0.8</td>
<td>16.0 ± 1.6</td>
<td>24.0 ± 8.5</td>
</tr>
<tr>
<td>cranial nerve defects</td>
<td>3.5 ± 0.5</td>
<td>4.9 ± 1.1</td>
<td>7.5 ± 1.9</td>
<td>4.0 ± 0.6</td>
</tr>
<tr>
<td>coordination defects</td>
<td>24.4 ± 2.0</td>
<td>15.2 ± 3.9</td>
<td>29.5 ± 2.1</td>
<td>29.7 ± 4.3</td>
</tr>
<tr>
<td>muscle tone changes</td>
<td>7.4 ± 1.0</td>
<td>9.1 ± 1.0</td>
<td>10.5 ± 1.3</td>
<td>10.7 ± 4.4</td>
</tr>
<tr>
<td>changes in reflexes</td>
<td>10.9 ± 1.5</td>
<td>8.9 ± 1.9</td>
<td>24.0 ± 0.0</td>
<td>13.3 ± 3.4</td>
</tr>
<tr>
<td>peripheral signs</td>
<td>3.5 ± 0.9</td>
<td>0.8 ± 0.3</td>
<td>11.7 ± 0.7</td>
<td>7.7 ± 5.0</td>
</tr>
<tr>
<td>muscle strength changes</td>
<td>2.7 ± 0.8</td>
<td>1.5 ± 0.9</td>
<td>8.5 ± 1.0</td>
<td>4.7 ± 2.9</td>
</tr>
</tbody>
</table>