



Various Clinical Approaches in Aphasia Diagnosis

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ABOUT THE STUDY

Aphasia is an acquired language disease in which individuals exhibit deficits in different parts of their language system (i.e., phonological, morphological, semantic, syntactic, and/or pragmatic) in about one-third of stroke patients. Aphasia is not a single condition and can manifest itself differently in each individual. Even within the same patient, symptoms of aphasia can vary dramatically, especially in the first few weeks and months after a stroke. The specific profile of language impairments is determined by a number of factors, including the size and location of the stroke, the patient's health history (e.g., diabetes, prior stroke history), access to quality medical care, how quickly medical treatment was received after the stroke, and the time since the stroke. Furthermore, even minor kinds of aphasia can have a negative impact on patients' lives, such as job loss, social isolation, despair, and a decreased quality of life.

The current diagnostic categorization distinguishes three PPA (Primary Progressive Aphasia) subtypes: Agrammatic (nfavPPA), semantic (svPPA), and logopenic (nfavPPA) (lvPPA). PPA commonly appears between the ages of 50 and 65. PPA eventually causes dementia, with an expected survival time of 10 to 15 years. So yet, no disease-modifying pharmaceutical intervention therapy is available. Non-pharmacological therapies, such as Speech and Language Therapy (SLT), have been shown to be effective in compensating for and maintaining functional communication.

Correct PPA diagnosis improves the chances of giving early appropriate therapeutic treatments, creating integrated care plans, controlling symptoms, increasing patient safety, cost savings, and delaying hospitalization. The neurodegenerative diagnostic trajectory is still being challenged, since various changes in diagnosis occur during PPA due to phenotypic progression from isolated linguistic problems to global cognitive impairment with accompanied diverse neuropsychiatric symptoms. Furthermore, lvPPA is thought to be an unusual

manifestation of Alzheimer's Disease (AD), complicating diagnosis even further. Even though the PPA length is anticipated to be roughly 6 years before dementia start, language problems may be the only set of symptoms for up to 10–14 years. After a few years of disease progression, deficiencies in cognitive areas other than language emerge, such as episodic memory or executive functioning. Throughout the deterioration process, however, the most noticeable symptom is linguistic impairment. PPA diagnosis is a significant difficulty in clinical practice since this phenotype is complicated and continually developing.

Despite the fact that PPA has been the subject of multiple research, due to its low prevalence, the majority of the extant literature deals with small sample sizes, which restricts statistical power and the generalizability of the conclusions. Conducting a full evaluation is critical for developing relevant and practical treatment objectives and activities. Furthermore, in light of the WHO ICF, aphasia evaluation must strive to get a thorough knowledge of how deficiencies have restricted the patient's daily living and social activities rather than merely detecting deficits. It is critical to begin with a thorough case history that includes background information such as employment, linguistic and cultural background, and medical history.

A complete aphasia examination considers every aspect of language (for example, syntax and semantics) in every modality (comprehending and expressing spoken language, written language, and gestures). The fluency and quality of spontaneous speech should be evaluated using activities such as visual description and open-ended inquiries. Confrontation naming exercises can be used to examine naming. Auditory understanding should be examined at several levels, including single words (nouns and verbs), phrases (both basic and complicated in syntax), and multi-step commands. It is also necessary to analyze the dependability of yes/no replies in order to determine whether the patient has more dependable yes/no responses using gestures *vs* speaking. Word, phrase, and sentence repetition should also be evaluated.

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