Watch Out for Psychiatric Illness After Mild TBI

Mild traumatic brain injury is a “silent epidemic,” according to the Centers for Disease Control and Prevention. But the condition has been generating a lot of noise recently. Reports of studies showing a link between mild traumatic brain injury, or concussion, and lingering alterations in cognitive and motor function in high-profile populations, such as U.S. soldiers returning from Iraq and Afghanistan, college athletes, and professional football players, have begun to give voice to the potential public health burden imposed by such injuries.

Generally defined as a head injury resulting from contact or acceleration or deceleration forces that induce an alteration of mental status (with or without a loss of consciousness) and a Glasgow Coma Scale score of 13-15, mild traumatic brain injury (mTBI) accounts for as many as 90% of all cases of head injury, World Health Organization estimates show. The term “mild” with respect to traumatic brain injury does not reflect the severity of the injury, but rather the length of time the individual experiences postinjury confusion or disorientation.

On the Glasgow Coma Scale, an injury causing less than 30 minutes of altered consciousness is deemed mild. To patients, families, and even clinicians, that comatose function might minimize the awareness of the potential for long-term symptoms. Since neuroimaging has become more readily available and the science has become more specific, mTBI and the possibility of postinjury symptoms have recently gained more traction. But there is still no way to show cause and effect between mTBI and the broad range of neuropsychiatric symptoms that have been attributed to it.

Until research catches up with reality, the best way to manage psychiatric symptoms in mTBI patients is to first identify such patients through routine history and, educate the patient and family, validate the patient’s symptoms, and treat with therapy and medication.

PREVENTION IN ACTION

BY CARL C. BELL, M.D.

Until recently, mild traumatic brain injury was presumed to be not very important for generating long-term symptoms or problems. In fact, this consideration was a huge source of contention among those who granted disability status of patients with mild TBI.

Also, disagreement prevailed within legal circles about various injury-related lawsuits, as most companies did not want to pay for the post-mTBI headaches, symptoms of depression, insomnia, and so forth.

Similarly, mTBI has been underconsidered as a source of psychiatric symptoms among mental health clinicians. Few psychiatrists routinely ask patients about mTBI. This mindset might be exacerbated by the fact that when there is no loss of consciousness associated with a head injury, individuals often don’t seek medical care, and by the measures used to gauge the severity of head trauma and the nomenclature used to describe it.

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