FOUR Score Challenges Glasgow Coma Scale

BY MICHELE G. SULLIVAN
Mid-Atlantic Bureau

A new coma assessment scale provides greater neurologic detail than the Glasgow system and has the potential to become the most effective means of evaluating unresponsive patients, according to researchers who developed it at the Mayo Clinic.

"The challenge over the years has been to produce a new scale that remains simple but still is comprehensive," said Eelco Wijdicks, M.D., who developed the Full Outline of Unresponsiveness (FOUR) Coma scale.

"Prior attempts to do this have been unsuccessful, largely because they had a more comprehensive scale that lost clarity and simplicity. This scale is very simple to use and greatly appreciated by nursing staff," Dr. Wijdicks said.

Graham M. Teasdale, M.B., inventor of the 30-year-old Glasgow scale, said the new system is more complicated largely because they had a more comprehensive scale that lost clarity and simplicity. This scale is very simple to use and greatly appreciated by nursing staff.

"The Glasgow Coma Scale was developed to fill the need for a practical method to assess impairment of consciousness in all types of patients with acute brain insult, in all places, by all kinds of staff, at all times, often minute by minute," Dr. Teasdale, professor emeritus of neurosurgery at the University of Glasgow, Scotland, said in an interview. The FOUR scale is applicable to a smaller proportion of patients and appears to be more complicated, he said.

"The major reason is that the GCS doesn’t include brain stem reflexes and respiration patterns, which reflect the severity of coma," Dr. Wijdicks, a neurologist at the Mayo Clinic, Rochester, Minn., said in an interview.

"Also, the eye component doesn’t involve voluntary eye movements and so can’t recognize visual tracking and a locked-in syndrome. Finally, he said, the GCS-verbal assessment is a moot point for intubated patients. The FOUR scale assesses voluntary and involuntary eye response; voluntary and involuntary motor response; respiration patterns; and brainstem response as measured by pupil and corneal reflexes. When using the FOUR system, evaluators assign a score of 0–4 in each category. A score of 4 represents normal functioning, while a score of 0 indicates nonfunctioning and should alert the physician to consider a brain death evaluation."

The eye component detects both locked-in syndrome, characterized by complete paralysis of voluntary muscles except for those that control eye movement, and vegetative state. The motor category assesses for the presence of myoclonus status, a poor prognostic sign after cardiac resuscitation. It combines decorticate and withdrawal responses, a difference Dr. Wijdicks said is often difficult to differentiate.

Breathing patterns are graded, because Cheyne-Stokes respiration and irregular breathing can represent bihemispheric or lower brainstem dysfunction.

A recently published validation study of FOUR included 120 neurointensive care unit patients, the largest validation study ever on coma scales, evaluated by pairs of neurointensivists (neurologists trained in critical care), neurologic nurses, and residents in different combinations. All raters were given the same training on using the system: 20 minutes’ instruction using videos, a single page of written instructions, and the opportunity to practice grading a few patients (Ann. Neurol. 2005; 58: 585–93).

Average patient age was 59 years, and their brain injuries were of mixed etiology, including hemorrhagic or ischemic stroke (24%), traumatic head injury (21%), brain tumor (11%), and other neurologic illness (13%).

Physician rater pairs scored the best, with good to excellent agreement. Nurse pairs had fair to moderate agreement.

Nurse agreement was highest on the respiration and motor components and lowest on the eye and brainstem components. The agreement of the nurses with residents and neurointensivists was good to excellent.

The lower nurse agreement could be one of the biggest drawbacks to the FOUR system, said Donald W. Marion, M.D., a fellow at the Brain Trauma Foundation in New York City. "If no one other than a specialist can use it, that’s a problem."

Dr. Teasdale agrees. "The study uses too restricted a range of staff—all were in a specialized tertiary critical care unit," he said. "What about the ‘average’ emergency room or hospital?"

The FOUR scale does succeed in getting around some of the biggest problems with GCS, including the issue of intubation, which negates the verbal assessment. But FOUR probably won’t be any more useful than GCS for traumatic brain injury patients, many of whom are sedated by the time they are assessed at a trauma center, Dr. Teasdale said.

Nevertheless, "there are some real pluses with it—most importantly, looking for pupil changes and corneal responses. That’s a real important improvement over the Glasgow score." The FOUR scale may be a good supplement to the GCS in some specific areas, but probably won’t supplant it, Dr. Teasdale said. "It must and will remain as a basic universal language. However, one of its benefits is its flexibility so it can be adapted, which is the essence of what Dr. Wijdicks has done, as have others in the past.”

FOUR Score

**EYE RESPONSE**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Eyelids open, tracking or blinking to command.</td>
</tr>
<tr>
<td>3</td>
<td>Eyelids open but not tracking.</td>
</tr>
<tr>
<td>2</td>
<td>Eyelids closed but open to loud voice.</td>
</tr>
<tr>
<td>1</td>
<td>Eyelids closed but open to pain.</td>
</tr>
<tr>
<td>0</td>
<td>Eyelids remain closed to pain.</td>
</tr>
</tbody>
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**MOTOR RESPONSE**

<table>
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<tbody>
<tr>
<td>4</td>
<td>Thumbs up, fist, or peace sign.</td>
</tr>
<tr>
<td>3</td>
<td>Localizing to pain.</td>
</tr>
<tr>
<td>2</td>
<td>Flexion response to pain.</td>
</tr>
<tr>
<td>1</td>
<td>Extension response.</td>
</tr>
<tr>
<td>0</td>
<td>No response to pain, or general myoclonus status.</td>
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</table>

**BRAIN STEM REFLEXES**

<table>
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<tr>
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<tr>
<td>4</td>
<td>Pupil and corneal reflexes present.</td>
</tr>
<tr>
<td>3</td>
<td>One pupil wide and fixed.</td>
</tr>
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<td>2</td>
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</tr>
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scoring the full outline of unresponsiveness

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To receive a copy of the FOUR packet instructional card, e-mail Dr. Wijdicks at wijde@mayo.edu.

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Source: Dr. Wijdicks

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Novel Drug Shows Promise for Sleep Initiation, Maintenance

BY BRUCE JANCIN
Denver Bureau

DENVER — Gaboxadol significantly improved sleep initiation and maintenance while also increasing time spent in restorative slow-wave sleep in an acute phase II placebo-controlled trial, Stephen Deacon, head of clinical development for sleep disorders at H. Lundbeck, Ltd., Milton Keynes, England.

The benzodiazepine receptor agonist, a class of drugs widely prescribed for insomnia, also targets γ-aminobutyric acid (GABA) receptors; however, their action is confined to synaptic GABA receptors. The extrapyramidal GABA-A receptors modulated by gaboxadol, highly present in parts of the brain thought to be important in sleep regulation, he explained.

Dr. Deacon reported on 26 adults with primary insomnia who participated in a double-blind, placebo-controlled polysomno-

graphic study. They received either 5 or 15 mg of gaboxadol or placebo half an hour before bedtime on two consecutive nights during three sessions separated by 1-2 weeks.

The low- and higher-dose gaboxadol reduced total nightly time awake by 15% and 16%, respectively, compared with the placebo.

In addition, gaboxadol at 15 mg increased the amount of time patients spent in slow-wave sleep by 21% over the mean 94 minutes with placebo. The mean 30-minute latency to persistent sleep on placebo decreased by 21% on nights when patients took 15 mg of the investigation animal.

Both doses of gaboxadol were well tolerated. There were no next-day residual drug effects.

The study was sponsored by H. Lundbeck, which is partnering with Merck & Co. to develop and market gaboxadol in the United States and Japan.