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Editorial

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Childhood concussion update 2014

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Editorial

Concussion (minimal traumatic brain injury: MTBI) has received a great deal of attention in the medical and lay press recently. While the clinical characteristics, diagnosis, and management of MTBI are becoming well delineated in patients over age 15, much less is known in younger children. Classic MTBI symptoms include: cognitive (i.e. slow thinking, poor memory), somatic (i.e. headache, photophobia), mood (i.e. agitation, demeanor change), and sleep related (i.e. less or interrupted) symptoms. Confounding factors in the young child include the persistent belief in adults that MTBI does not occur in young children, inability of children to communicate symptoms, neurodevelopment immaturity, and wide neurodevelopmental variations. In addition, unique symptoms may occur such as specific cognitive deficits (i.e. dyscalculia) and behavior change. Similarly, young children may be subjected to symptom triggers repeatedly in the school environment such as bus rides, loud sharp noises, white teaching boards, and prolonged school days. As more research appears in the literature, there is a trend toward the belief in a longer recovery period than previously anticipated due to brain injury clinically unrecognizable but demonstrated on specialized testing such as PET or tensor scans. Thus, the diagnostic term of post-concussion syndrome is becoming less descriptive since it is uncertain when the MTBI actually ends. In all age groups it remains difficult to definitively state when an MTBI victim is medically cleared to return to sports. Nonetheless, the management of MTBI still follows fundamental tenets including: the presence of trained sideline professionals, improvement in game rules and equipment, Immediately removal from activity if an MTBI is suspected, evaluation for catastrophic brain injury as indicated, initial cognitive and physical rest, dietary management, early and recurrent evaluation by a professional well versed in MTBI management, diagnostics as indicated including cognitive (i.e. Impact testing), balance evaluation, ocular testing, symptom management (i.e. nausea, headache), rehabilitative interventions related to diagnostic findings, gradual reintegration into cognitive and physical activity, and very cautious return to participation in head threatening activities. Professionals must pay close attention to the medical literature as the scope of MTBI understanding is rapidly advancing and the severity and resolution of brain injury with MTBI is far greater than previously thought.

Acknowledgments

None.

Conflicts of Interset

None.