



DEFENSE CENTERS OF EXCELLENCE
For Psychological Health & Traumatic Brain Injury

Identifying Concussion / Mild TBI in Service Members

DCoE Monthly Webinar, March 22, 2012

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Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury



Additional Webinar Details

- Continuing education units and continuing medical education credits
 - Webinar pre-registration **REQUIRED** to receive CEUs or CME credits
 - Registration open for next 15 minutes; Register at <https://dcoe.adobeconnect.com/dcoewebinar/event/registration.html>
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 - Dial: **888-455-4265**
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- Webinar information
 - Visit www.dcoe.health.mil/webinars
- Question-and-Answer Session
 - Submit questions via the Adobe Connect or Defense Connect Online question box

Agenda

- Welcome and Introduction
- Presentations
 - Dr. David L. Brody
 - Epidemiology and Impact of Concussion / Mild TBI in Service Members
 - Lt. Tracie B. Lattimore, RN, MSN, NP-C
 - Screening for Concussion / Mild TBI in Service Members
 - Cmdr. Michael Handrigan, M.D., FACEP
 - Mild TBI Pocket Guide (CONUS)
- Question-and-Answer Session / Discussion

Webinar Overview

Identifying Concussion / mTBI in Service Members

- Mild TBI is the most common form of TBI sustained in the military
- Unlike a severe or moderate TBI, mild TBI may not be easily identified
- Early detection is important
- The impact of mild TBI in service members will be discussed
- Screening programs implemented across the Defense Department will be described
- Some of the challenges associated with screening will be addressed



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Epidemiology and Impact of Concussion / Mild TBI in Service Members

David L. Brody, M.D., Ph.D.

Associate Professor of Neurology
Washington University School of Medicine



Required Disclaimer

I have no relevant financial relationships and do not intend to discuss the off-label / investigative (unapproved) use of commercial products/devices.

DoD Definition of TBI

- A traumatically induced structural injury and/or physiological disruption of brain function as a result of external force that is indicated by new onset or worsening of at least one of the following clinical signs, immediately following the event:
 - Loss of or a decreased level of consciousness
 - Loss of memory for events immediately before or after the injury
 - Alteration in mental state at the time of the injury (confusion, disorientation, slowed thinking, etc.)
 - Neurological deficits (weakness, loss of balance, change in vision, praxis, paresis/plegia, sensory loss, aphasia, etc.) that may or may not be transient
 - Intracranial lesion

DoD Definition of TBI – External Forces

- External forces may include any of the following events:
 - The head being struck by an object
 - The head striking an object
 - The brain undergoing an acceleration/deceleration movement without direct external trauma to the head
 - A foreign body penetrating the brain
 - Forces generated from events such as blast or explosion, or other force yet to be defined (Defense Department, 2007)

DoD Definition of Concussion / Mild TBI

- Normal structural imaging
- Loss of consciousness = 0-30 minutes
- Alteration of consciousness = a moment up to 24 hours
- Post-traumatic amnesia = 0-1 day
- These are typically 80-90 percent of all TBIs

Reference: http://www.dvbic.org/pdf/Department_of_Defense_Coding_Guidance_Traumatic_Brain_Injury_Fact_Sheet.pdf

TBI Incidence Totals

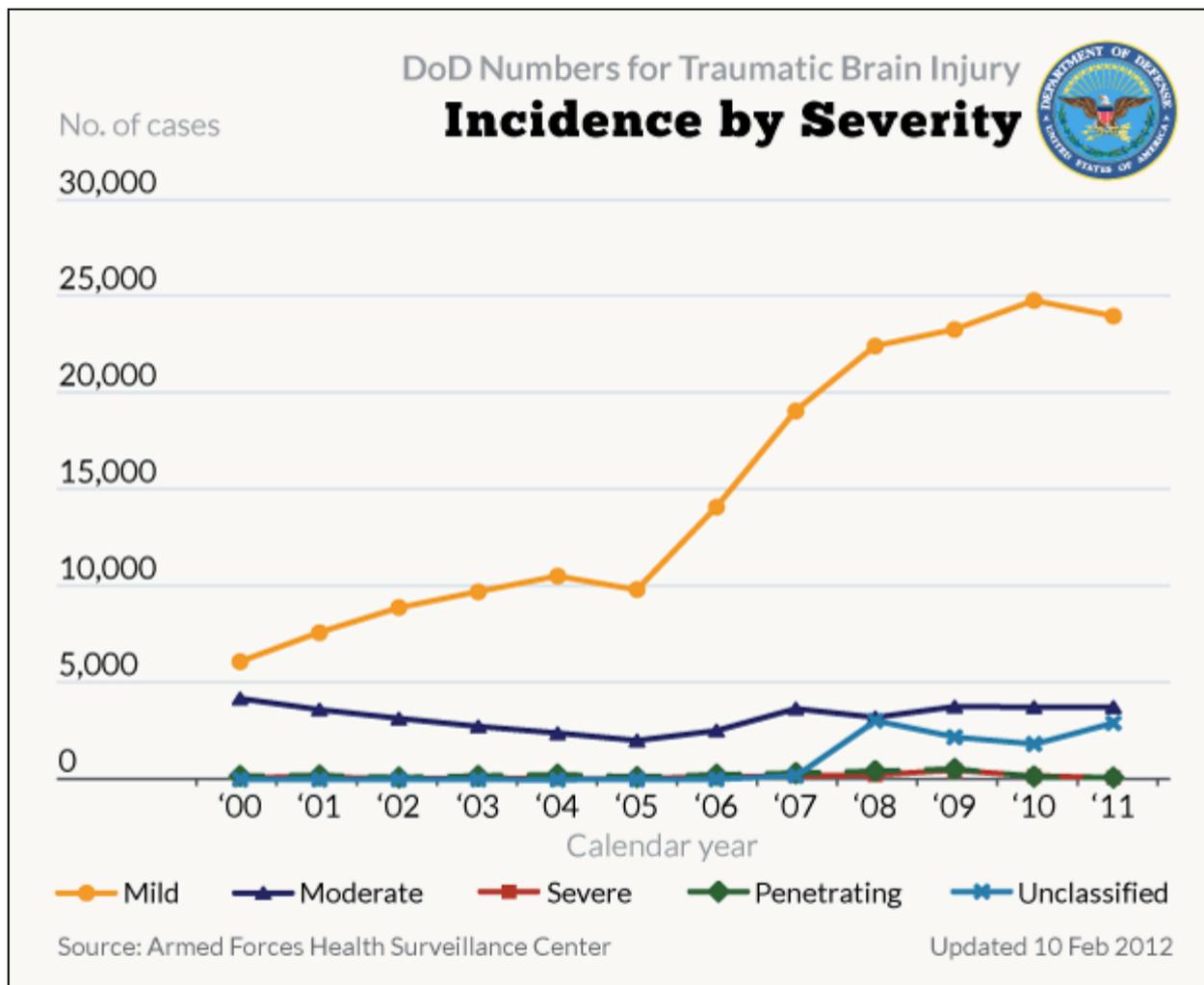
Military TBI incidence

- Defense and Veterans Brain Injury Center (DVBIC) website
 - 233,425 clinician diagnosis, 2000-2011
- RAND Report, 2008*
 - 19 percent of deployed 320,000
 - Extrapolated from telephone survey of 1,965 deployed individuals in 2007-2008

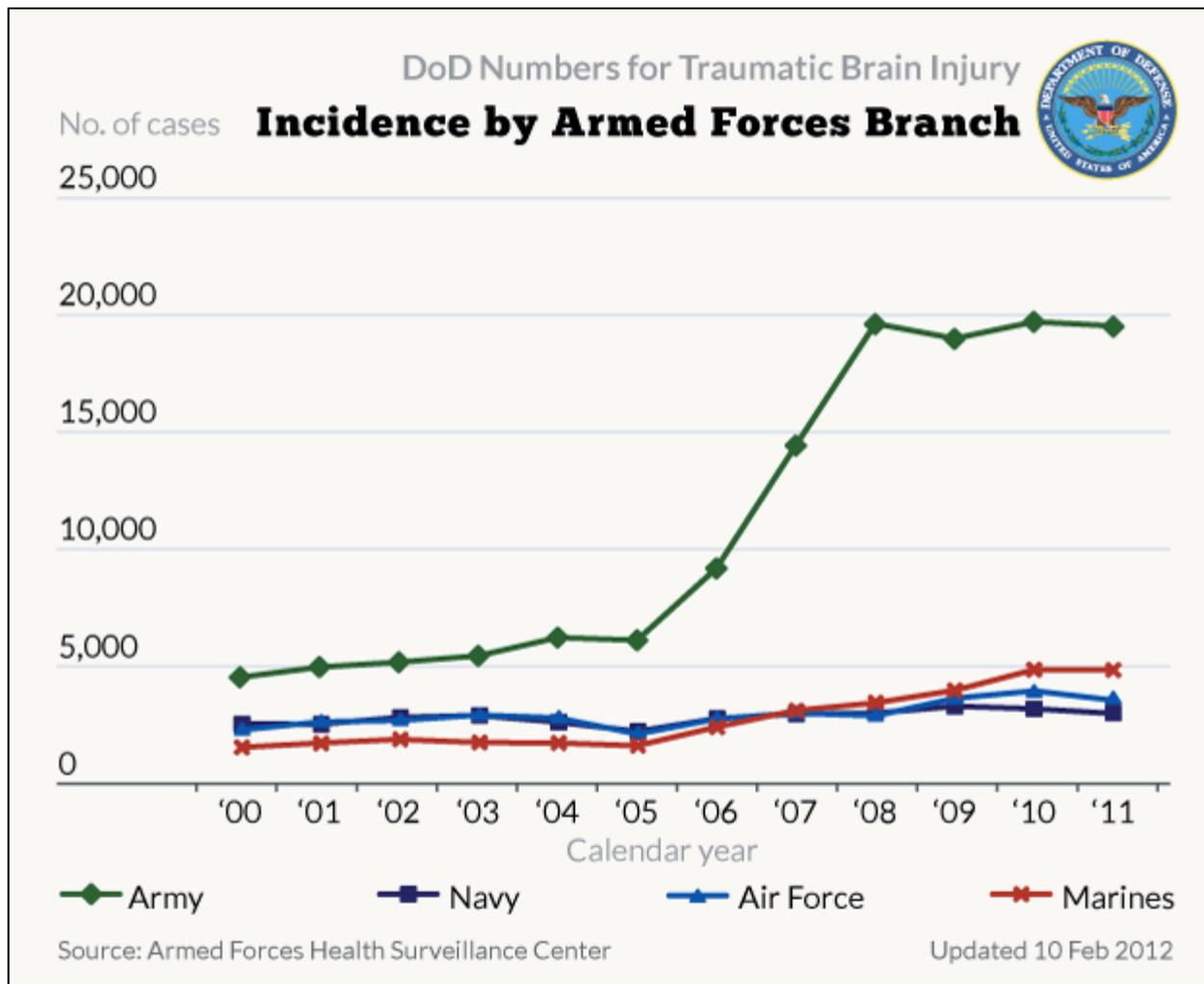
U.S. civilians, 2004

- 1.7 million per year

DoD Worldwide TBI Incidence by Severity



DoD Worldwide TBI Incidence by Service



Causes of Concussion / Mild TBI

- Causes* (More than one cause was common)
 - Blast: 73-79 percent
 - Bullet: 1-5 percent
 - Fragment or shrapnel: 18-25 percent
 - Fall: 28-30 percent
 - Vehicle accident: 18-30 percent
 - Other: 9-13 percent

**Based on survey of 2,525 Army infantry soldiers three to four months after return from Iraq in 2006 of which 384 (15 percent) reported concussion in the previous year.*

Multiple Injuries

- Very little is known
- One study reported:
 - 0.7 percent (113 of 14,653) had two or more concussions
 - Median time between concussions equals 40 days
 - Based on reports from 2004-2008 in Iraq treated at Navy/Marine Corps facilities
 - Likely substantially under-reported based on date of study and Marine population

Multiple Injuries

- 17 percent of 1,502 infantry soldiers with heavy combat exposure in Iraq and Afghanistan reported TBI (based on self-report and not physician diagnosis)
- Of these 153/260 reported more than one TBI during their last deployment
- Has not been validated with direct physician diagnoses
- Important because multiple concussions are often associated with slower recovery and increased risk of long-term sequelae

Reference: *Wilk et al., *Psychosom Med* 2012

Bottom Line

- 10-20 percent of U.S. military personnel will experience a traumatic brain injury
- 80-90 percent of these are mild
- Nearly 80 percent are blast-related
- Unknown how many are multiple

Impact / Overview

- Headaches, both migraine and other types
- Sleep disturbances, initially hypersomnia later insomnia
- Fatigue
- Balance dysfunction
- Tinnitus
- Subjective cognitive complaints, but typically normal performance on objective tests
- Emotional dysregulation including depression and post-traumatic stress disorder
- Alcohol misuse

Historical Perspective: World War I

- During World War I, Dr. Mott described soldiers exposed to blast with:
 - “coarse tremors”
 - “inability to walk or do anything”
 - “melancholia”
- At autopsy, multiple small hemorrhages in brain and other organs

Reference: Journal of the Royal Army Medical Corps, 1917

Historical Perspective: World War II

Dr. Fabing described a group of 80 patients exposed to blast and rendered unconscious.

- These patients reported:
 - minutes to hours of anterograde amnesia
 - intractable headache in variable locations
 - noise sensitivity
 - tinnitus (transient or persistent)
 - varying anxiety symptoms, including exaggerated startle, disturbing dreams, tremor and social isolation
 - insomnia
- None had focal neurological deficits or cerebrospinal fluid abnormalities

Reference: Archives of Neurology and Psychiatry, 1947

Headaches

- Commonly reported in many series:
 - 50-80 percent in the acute phase¹
 - 18-32 percent in U.S. military personnel three to four months after mild TBI²
 - 40 percent in blast-related versus 22 percent in non-blast-related TBI patients³

While approximately 20 percent of the general population suffers from migraine headaches, often the frequency and intensity of headaches are greatly increased after TBI.

References: 1. Luethcke JINS 2011
2. Hoge et al., NEJM, 2008
3. Wilk, J Head Trauma Rehab 2010

Sleep Disorders and Fatigue

- Self-reported in 40-54 percent of mild TBI patients¹
- Self-reported in 60 percent of blast-related and 65 percent of non-blast-related TBI patients²

References: 1. Hoge et al., *NEJM*, 2008
2. Wilk, *J Head Trauma Rehab* 2010

Balance Dysfunction and Tinnitus

- Self-reported ringing in the ears in 34 percent of blast-related and 15 percent of non-blast-related TBI patients¹
- Dizziness in 39 percent, vertigo in 24 percent and oscillopsia (instability of the visual scene) acutely after blast-related TBI²
- Both peripheral and central vestibular dysfunction on rotational chair testing³

References: 1. Wilk, *J Head Trauma Rehab* 2010
2. Scherer *Mil Med* 2007
3. Scherer *Otol Neurotol* 2011

Cognitive Complaints

- Self-reported cognitive concerns include:
 - Memory problems (21-40 percent)
 - Concentration problems (24-45 percent)¹
- These symptoms were similar in blast-related versus non-blast-related mild TBI²

References: 1. Wilk, *Psychosomatic Med* 2012
2. Wilk, *J Head Trauma Rehab* 2010;
Lippa, *J International Neuropsychological Society* 2010

Cognitive Performance

Neuropsychological testing has generally revealed normal performance at subacute to chronic time points.

- Standard tests of attention, working memory and verbal learning were normal in 27 chronic TBI patients¹
- Function was similarly normal in 27 mTBI patients with persistent symptoms and 18 without symptoms²
- An independent group reported no objective deficits executive function, working memory, visual memory or verbal memory in either blast-related or non-blast related chronic mTBI patients³

References: 1. Brenner, *Military Med* 2009
2. Brenner, *Neuropsychol* 2010
3. Belanger, *J Int Neuropsych Soc* 2009

Cognitive Performance

- Slowed cognitive reaction times reported in U.S. military personnel with both acute blast-related and non-blast-related mild TBI
- Severity related to duration of loss of consciousness

Emotional Dysregulation, Including Depression and Post-traumatic Stress Disorder

- In 968 veterans, a median 2.5 years after deployment:¹
 - 47-70 percent with mild TBI also had symptoms of PTSD versus 23 percent without TBI
 - Likewise 23-45 percent had depression versus 15 percent without TBI
 - Highest rates in subjects with blast plus other mechanisms of injury
- 51 percent with major depression within one year after civilian TBI²
- Similarly high rates in U.S. military personnel with both blast-related and non-blast-related mild TBI³

References: 1. Maguen, *J Traumatic Stress* 2012
2. Bombardier *JAMA* 2010
3. Lippa *J International Neuropsychological Society* 2010

Endocrine Dysfunction

- 11/26 subjects with blast-related mild TBI had abnormal pituitary hormone levels, most commonly:
 - Insulin-like growth factor (IGF)-1: 5/26
 - Testosterone and Lutenizing Hormone: 3/26
 - Vasopressin: 4/26; two low, two high
 - Oxytocin: 4/26
 - Prolactin: 2/26; one low, one high
- Functional implications nor the effects of hormone replacement are known
- Thyroid hormone, cortisol levels generally normal

Alcohol Misuse

- Self-reported in 39 percent of blast-related and 42 percent of non-blast-related TBI patients¹
- Alcohol abuse reported in 44-62 percent of U.S. military personnel with mild TBI, versus 40 percent of those without TBI²

References: 1. Wilk, *J Head Trauma Rehab* 2010
2. Maguen, *J Traumatic Stress*, 2012

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First Polling Question

Are you a health care provider?

Select “YES”

or

Select “NO”



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Screening for Concussion / mTBI in Service Members

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Outline

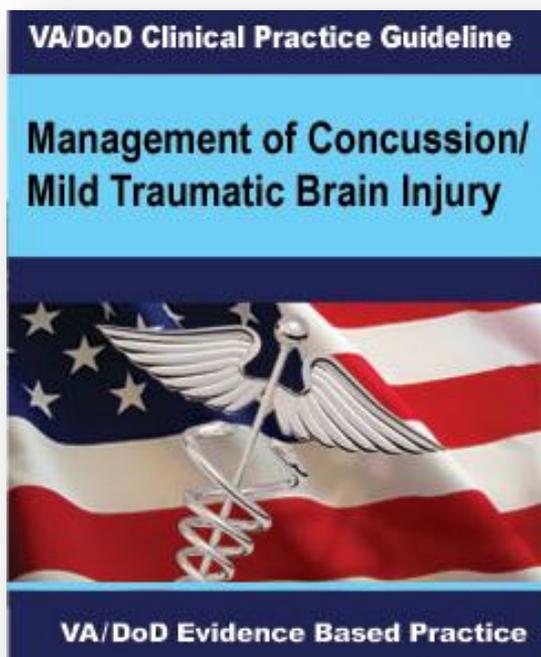
- Background
- Challenges in screening for concussion
- Defense Department screening programs
- Way ahead

Key Traumatic Brain Injury Guidance

Garrison

2009 VA-DoD CPGs

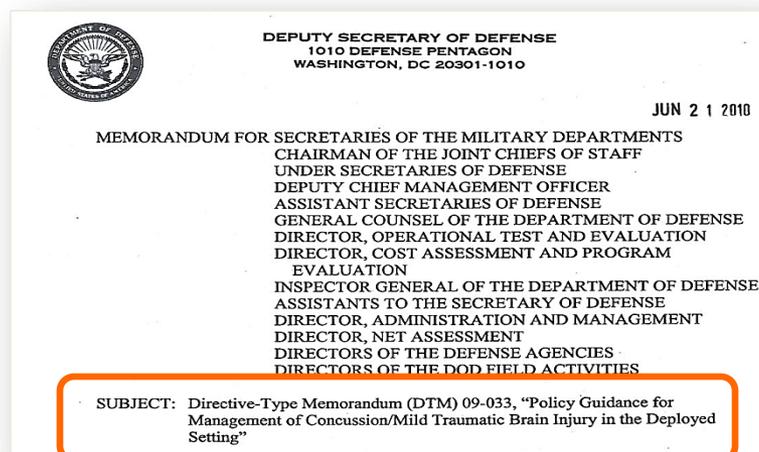
- Highest-rated mTBI CPG in a 2011 research study published in *Brain Injury*



In Theater

DTM 09-033

- Event-based protocol: line and medical responsibilities
- Mandates rest period and medical screening
- Specialized evaluation for multiple concussion



Screening Challenges for the Military

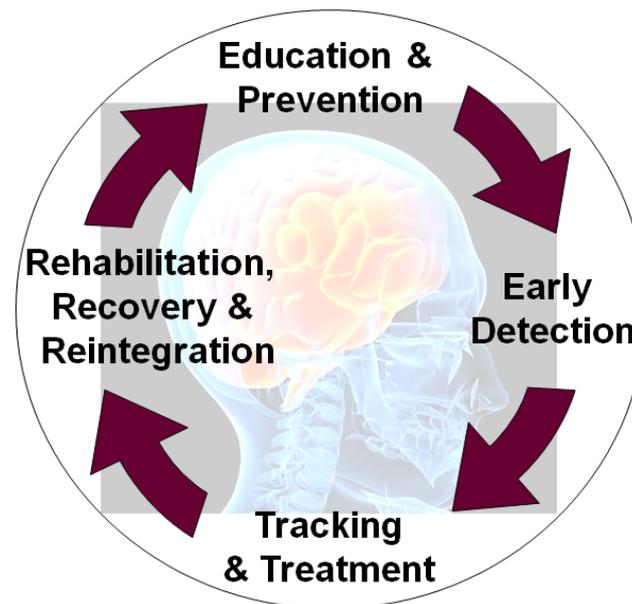
- **Concussions that occur in theater occur under unique circumstances:**
 - In the context of sleep deprivation, nutrition changes, emotional stress
 - With a need for rapid assessment of return to duty status
 - Unique mechanisms of injury
 - Difficult environmental factors
 - Desire to return to the fight
- **Polytrauma patients**
 - Landstuhl / Walter Reed National Military Medical Center

Army Strategy for Concussion Management



Concussion/ mTBI Management

- **Goal:** a cultural change following concussive events
- **Vision:** Every Warrior treated appropriately to minimize concussive injury and maximize recovery
- **Mission:** Produce an educated force trained and prepared to provide early recognition, treatment & tracking of concussive injuries in order to protect Warrior health



Directive-Type Memorandum 09-033

Goal: Screen all potentially concussed service members and ensure adequate treatment at point of injury

- **Event driven protocols:** Exposure to potentially concussive events require mandatory medical evaluation and **24-hour rest period** (downtime)
- All sports and activities with risk of concussion are prohibited until **medically cleared**
- Military Acute Concussion Evaluation (MACE) documentation includes **three-part score**
- Concussed soldiers will be given a **standardized educational sheet**
- New protocols for anyone sustaining **multiple** concussions within 12 months
- Shared responsibilities between **medical and line**

Mandatory Screening Events in Theater

Four mandatory events per DTM 09-033:

- Any service member in a vehicle associated with a blast event, collision, or rollover
- All within 50 meters of a blast (inside or outside)
- Anyone who sustains a direct blow to the head
- Command directed
 - Including, though not limited to, repeated exposures to blasts



Actions Following Mandatory Events

Line/Leadership Actions

- **Screen: Injury, Evaluation, Distance checklist**
 - Ensures leaders have “eyes-on”
 - Does not replace the medical evaluation
- **Rest: Enforce minimum 24-hour mandatory rest**
- **Report: Using BECIR / CIDNE**

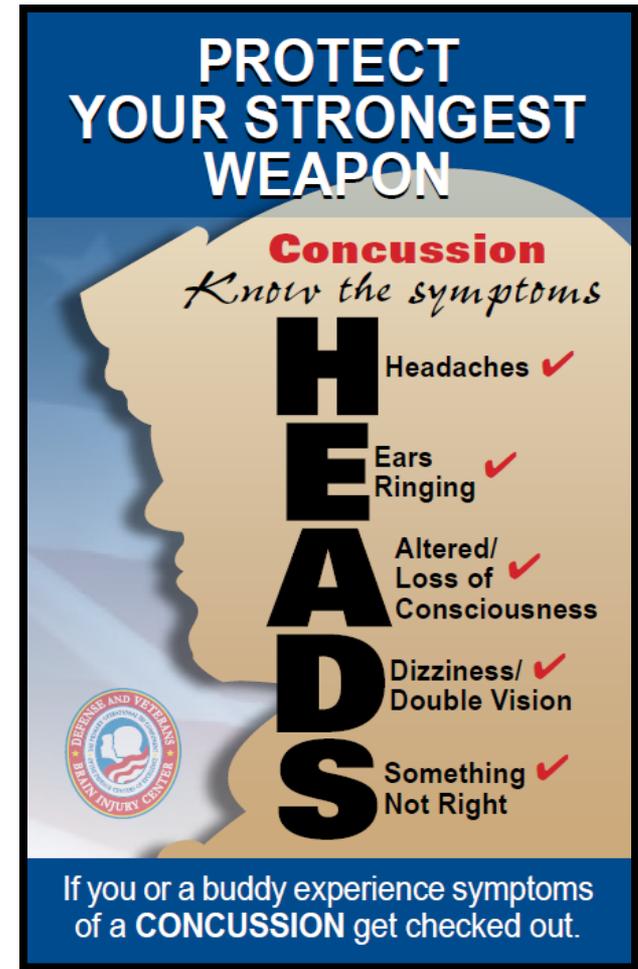
Medical Actions

- **Evaluate: Military Acute Assessment Evaluation (MACE)**
 - Medical algorithms guide care
 - Algorithm for recurrent concussion
- **Report: Screening and treatment encounters**
 - Enter note into electronic medical record

*Note: Combined Information Data Network Exchange (CIDNE)
Blast Exposure and Concussion Incident Report (BECIR)*

Leadership Assessment (Screening)

- **Injury:**
 - Physical damage to service member's body or body part? (Yes/No)
- **Evaluation:**
 - H*E*A*D*S
- **Distance:**
 - Was service member within 50 meters of blast? (Yes/No)
 - Record the distance from blast for **all** service members
- **Documentation:**
 - Significant activities report (CIDNE / BECIR)



Note: Combined Information Data Network Exchange (CIDNE)
Blast Exposure and Concussion Incident Report (BECIR)

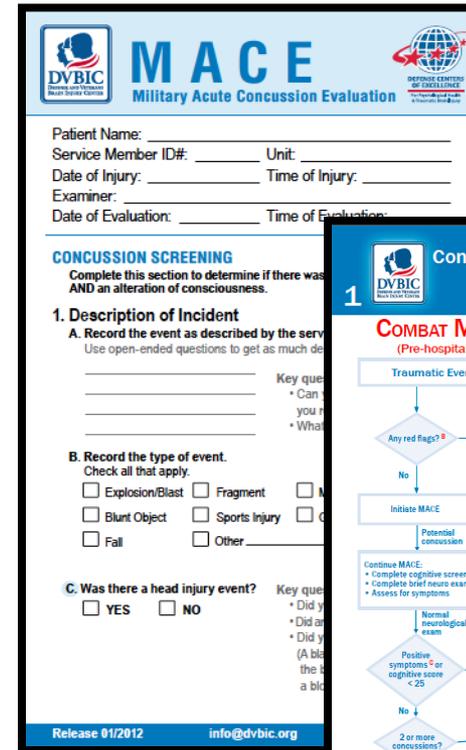
Medical Management of Concussion in Theater

■ Screenings:

- Medical screening / evaluation with algorithms
- Post-Deployment Health Assessment and Post-Deployment Health Re-assessment (PDHA and PDHRA)

■ Assessment Tools:

- Military Acute Assessment Evaluation (MACE)
- Automated Neurological Assessment Metrics (ANAM)



MACE
Military Acute Concussion Evaluation

Patient Name: _____
Service Member ID#: _____ Unit: _____
Date of Injury: _____ Time of Injury: _____
Examiner: _____
Date of Evaluation: _____ Time of Evaluation: _____

CONCUSSION SCREENING
Complete this section to determine if there was AND an alteration of consciousness.

1. Description of Incident
A. Record the event as described by the service member.
Use open-ended questions to get as much detail as possible.

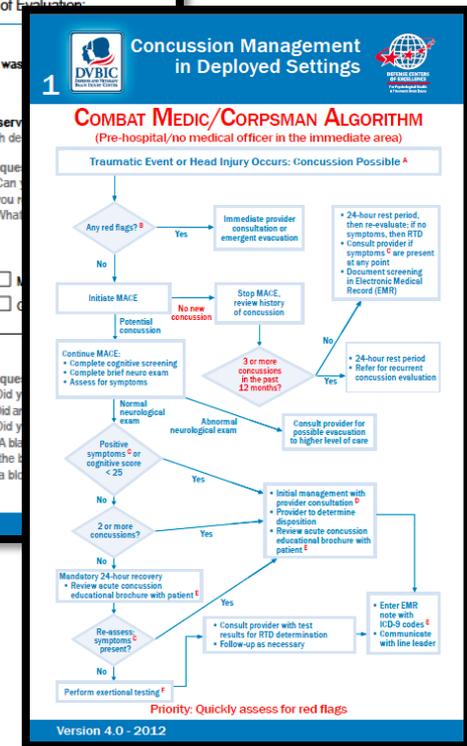
Key questions:
• Can you remember the event?
• What were you doing?
• What were you thinking?

B. Record the type of event.
Check all that apply.
 Explosion/Blast Fragment Other
 Blunt Object Sports Injury Other
 Fall Other

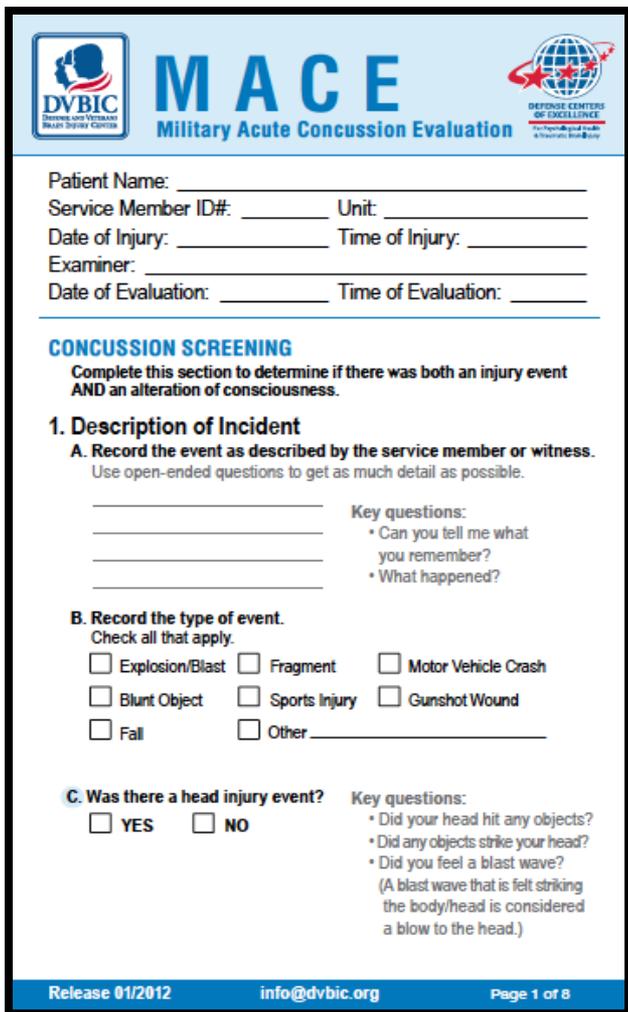
C. Was there a head injury event?
 YES NO

Key questions:
• Did you feel a blow to the head?
• Did you feel a blow to the face?
• Did you feel a blow to the neck?
• Did you feel a blow to the shoulder?
• Did you feel a blow to the back?
• Did you feel a blow to the arm?
• Did you feel a blow to the leg?
• Did you feel a blow to the hand?
• Did you feel a blow to the foot?

Release 01/2012 info@dvbic.org



Military Acute Concussion Evaluation (MACE)



The image shows the MACE (Military Acute Concussion Evaluation) form. It includes a header with the DVBIC logo and the text 'MACE Military Acute Concussion Evaluation'. Below the header are fields for Patient Name, Service Member ID#, Unit, Date of Injury, Time of Injury, Examiner, Date of Evaluation, and Time of Evaluation. The main section is titled 'CONCUSSION SCREENING' and contains three parts: 1. Description of Incident, 2. Record the type of event, and 3. Was there a head injury event? Each part includes key questions and checkboxes for various injury types.

MACE
Military Acute Concussion Evaluation

Patient Name: _____
Service Member ID#: _____ Unit: _____
Date of Injury: _____ Time of Injury: _____
Examiner: _____
Date of Evaluation: _____ Time of Evaluation: _____

CONCUSSION SCREENING
Complete this section to determine if there was both an injury event AND an alteration of consciousness.

1. Description of Incident
A. Record the event as described by the service member or witness.
Use open-ended questions to get as much detail as possible.

Key questions:
• Can you tell me what you remember?
• What happened?

B. Record the type of event.
Check all that apply.

Explosion/Blast Fragment Motor Vehicle Crash
 Blunt Object Sports Injury Gunshot Wound
 Fall Other _____

C. Was there a head injury event?

YES NO

Key questions:
• Did your head hit any objects?
• Did any objects strike your head?
• Did you feel a blast wave?
(A blast wave that is felt striking the body/head is considered a blow to the head.)

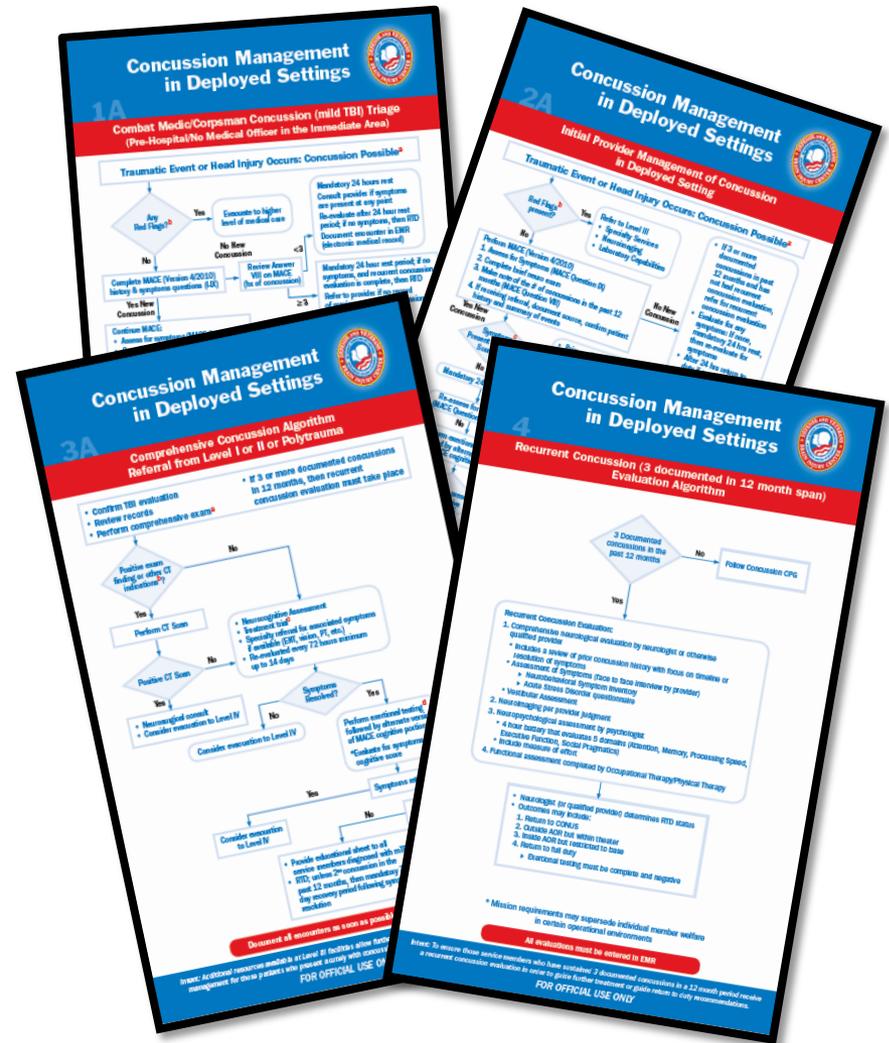
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- A standardized clinical interview and exam to screen for concussion
- Questions 1A-C aid in establishing details of the current incident, including:
 - Description of the event
 - The type of event
 - Was there a head injury event
- Questions 2A-C determine if there was alteration of consciousness or memory lapses:
 - Was there AOC?
 - Was there LOC?
 - Was there PTA?

Note: Alteration of consciousness (AOC)
Loss of consciousness (LOC)
Post-traumatic amnesia (PTA)

Clinical Algorithms

- The DTM includes four clinical algorithms to guide all levels of providers through medical management of concussion / mild TBI:
 - Combat Medic / Corpsman
 - Initial Provider
 - Comprehensive Clinical Evaluation
 - Recurrent Concussion Evaluation



Appropriate Use of the Automated Neurological Assessment Metrics (ANAM)

Intended:

- To inform post injury RTD recommendations
- To provide cognitive evaluation for symptomatic service members identified by post-deployment screening

Not Intended:

- As a diagnostic tool for concussion
- As an acute screen for the presence of concussion
- To be the sole source of information regarding triage or return to duty
- For population-based TBI post-deployment screening

Note: Return to duty (RTD)

Post-Deployment Health Assessment

- Self-report
 - Army has automatic flag tied to CIDNE / BECIR data
- Flags require immediate follow-up evaluation
 - Evaluation can trigger referral to appropriate provider

<p>9.a. During this deployment, did you experience any of the following events? <i>(Mark all that apply)</i></p> <p>(1) Blast or explosion (IED, RPG, land mine, grenade, etc.) <input type="radio"/> No <input type="radio"/> Yes</p> <p>(2) Vehicular accident/crash (any vehicle, including aircraft) <input type="radio"/> No <input type="radio"/> Yes</p> <p>(3) Fragment wound or bullet wound above your shoulders <input type="radio"/> No <input type="radio"/> Yes</p> <p>(4) Fall <input type="radio"/> No <input type="radio"/> Yes</p> <p>(5) Other event (for example, a sports injury to your head). Describe: <input type="radio"/> No <input type="radio"/> Yes</p>	<p>9.b. Did any of the following happen to you, or were you told happened to you, IMMEDIATELY after any of the event(s) you just noted in question 9.a.? <i>(Mark all that apply)</i></p> <p>(1) Lost consciousness or got "knocked out" <input type="radio"/> No <input type="radio"/> Yes</p> <p>(2) Felt dazed, confused, or "saw stars" <input type="radio"/> No <input type="radio"/> Yes</p> <p>(3) Didn't remember the event <input type="radio"/> No <input type="radio"/> Yes</p> <p>(4) Had a concussion <input type="radio"/> No <input type="radio"/> Yes</p> <p>(5) Had a head injury <input type="radio"/> No <input type="radio"/> Yes</p>
<p>9.c. Did any of the following problems begin or get worse after the event(s) you noted in question 9.a.? <i>(Mark all that apply)</i></p> <p>(1) Memory problems or lapses <input type="radio"/> No <input type="radio"/> Yes</p> <p>(2) Balance problems or dizziness <input type="radio"/> No <input type="radio"/> Yes</p> <p>(3) Ringing in the ears <input type="radio"/> No <input type="radio"/> Yes</p> <p>(4) Sensitivity to bright light <input type="radio"/> No <input type="radio"/> Yes</p> <p>(5) Irritability <input type="radio"/> No <input type="radio"/> Yes</p> <p>(6) Headaches <input type="radio"/> No <input type="radio"/> Yes</p> <p>(7) Sleep problems <input type="radio"/> No <input type="radio"/> Yes</p>	<p>9.d. In the past week, have you had any of the symptoms you indicated in 9.c.? <i>(Mark all that apply)</i></p> <p>(1) Memory problems or lapses <input type="radio"/> No <input type="radio"/> Yes</p> <p>(2) Balance problems or dizziness <input type="radio"/> No <input type="radio"/> Yes</p> <p>(3) Ringing in the ears <input type="radio"/> No <input type="radio"/> Yes</p> <p>(4) Sensitivity to bright light <input type="radio"/> No <input type="radio"/> Yes</p> <p>(5) Irritability <input type="radio"/> No <input type="radio"/> Yes</p> <p>(6) Headaches <input type="radio"/> No <input type="radio"/> Yes</p> <p>(7) Sleep problems <input type="radio"/> No <input type="radio"/> Yes</p>

Note: Combined Information Data Network Exchange (CIDNE)
Blast Exposure and Concussion Incident Report (BECIR)

Way Ahead

- Translate theater successes to garrison setting
 - Policy, databases, education, standardized systems of care
- Maximizing education/training for medical and line assets
- Partnerships with civilian and Defense Department experts
- Translate research into clinical practice

Thank You

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Polling Question

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to obtain CEUs or CMEs?

Select “YES”

or

Select “NO”



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Mild TBI Pocket Guide (CONUS)

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Department of Veterans Affairs Consensus Conference on Mild TBI, PTSD and Pain

Recommendations:

- Most effective treatment strategies include current CPGs for the three co-morbidities
- Understanding guidance in all three guidelines is challenge to providers
- Need brief clinical support tool that brings together the three guidelines in a way that clinicians can actually use

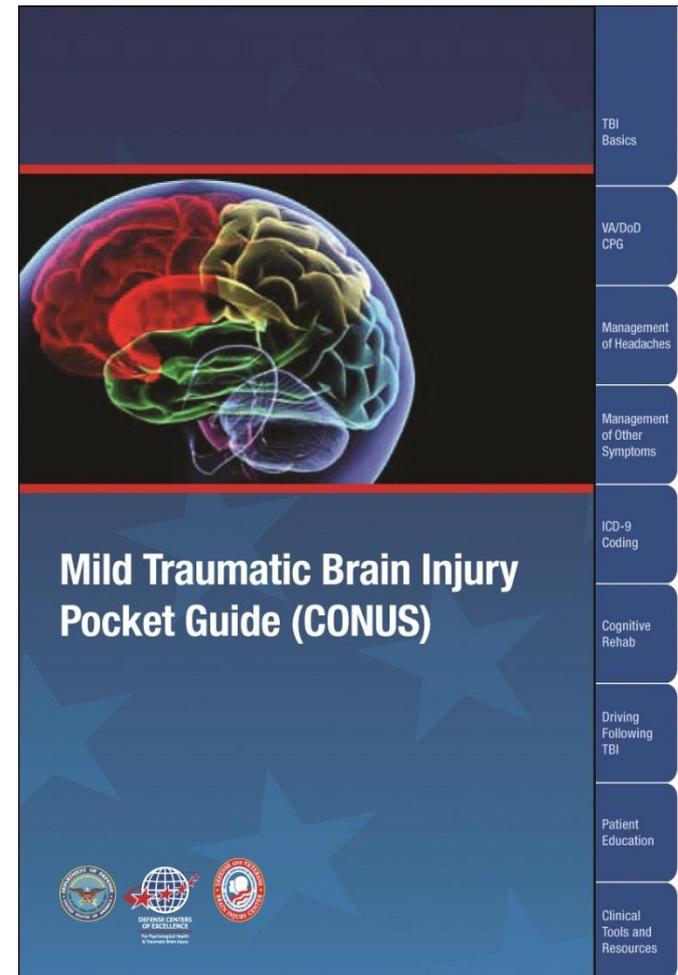


Note: Clinical Practice Guideline (CPG)

Reference: Dept. of Veterans Affairs Consensus Conference on mTBI, PTSD and Pain, June 2009.

Mild TBI Pocket Guide (CONUS)

- Quick-reference resource on treatment and management of mild TBI including:
 - Evidence-based recommendations
 - ICD-9 coding guidance
 - Clinical recommendations for cognitive rehabilitation
 - Clinical recommendations on assessing ability to drive safely
 - Patient education materials
 - Clinical tools and resources
- Free copies of pocket guide can be ordered through DCoE website



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If you pre-registered for this webinar and want to obtain a continuing education certificate, you must complete the online CEU/CME evaluation.

- Did you pre-register **PRIOR** to Sunday, March 18, 2012?
 - **If Yes**, please visit conf.swankhealth.com/dcoe to complete the online CEU/CME evaluation and download your continuing education certificate.

- Did you pre-register between Monday, March 19, 2012, and now?
 - **If Yes**, your online CEU/CME evaluation and continuing education certificate **will NOT be available** until Monday, March 26.

- The Swank Health website will be open until April 23, 2012.
 - **If you did not pre-register**, you will **NOT** be able to receive CE credit for this event.

Save the Date

DCoE Monthly Webinar:

*Children of Deployed
Parents: Health Care
Provider Strategies for
Enhancing Coping Skills*

April 26, 2012
1-2:30 p.m. (EST)

APRIL						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

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