Epidemiology of Postconcussion Syndrome in Pediatric Mild Traumatic Brain Injury
Karen Maria Barlow, Susan Crawford, Andrea Stevenson, Sandeep Sona Sandhu, François Belanger and Deborah Dewey

*Pediatrics* 2010;126:e374-e381; originally published online Jul 26, 2010;
DOI: 10.1542/peds.2009-0925

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://www.pediatrics.org/cgi/content/full/126/2/e374
Epidemiology of Postconcussion Syndrome in Pediatric Mild Traumatic Brain Injury

WHAT’S KNOWN ON THIS SUBJECT: There is much disagreement as to whether PCS can be attributed to a brain injury or other factors such as trauma alone, preexisting psychosocial problems, or medicolegal issues.

WHAT THIS STUDY ADDS: This study investigated PCS in a large pediatric population. The results supported the validity of PCS and indicated that a child with PCS who is still symptomatic 100 days after mTBI has a 40% likelihood of remaining symptomatic for the following month.

abstract

BACKGROUND: Much disagreement exists as to whether postconcussion syndrome (PCS) is attributable to brain injury or to other factors such as trauma alone, preexisting psychosocial problems, or medicolegal issues. We investigated the epidemiology and natural history of PCS symptoms in a large cohort of children with a mild traumatic brain injury (mTBI) and compared them with children with an extracranial injury (ECI).

METHODS: This investigation was a prospective, consecutive controlled-cohort study of 670 children who presented to a tertiary referral emergency department with mTBI and 197 children who presented with ECI. For all participants, data were collected by use of a telephone interview of a parent 7 to 10 days after injury. If a change from preinjury symptoms was reported by a parent, follow-up continued monthly until symptom resolution. Outcomes were measured by using the Post Concussion Symptom Inventory, Rivermead Postconcussion Symptom Questionnaire, Brief Symptom Inventory, and Family Assessment Device.

RESULTS: There was a significant difference between the mTBI and ECI groups in their survival curves for time to symptom resolution (log rank [Mantel-Cox] 11.15, P < .001). Three months after injury, 11% of the children in the mTBI group were symptomatic (13.7% of children older than 6 years) compared with 0.5% of the children in the ECI group. The prevalence of persistent symptoms at 1 year was 2.3% in the mTBI group and 0.01% in the ECI group. Family functioning and maternal adjustment did not differ between groups.

CONCLUSIONS: Among school-aged children with mTBI, 13.7% were symptomatic 3 months after injury. This finding could not be explained by trauma, family dysfunction, or maternal psychological adjustment. The results of this study provide clear support for the validity of the diagnosis of PCS in children. Pediatrics 2010;126: e374–e381

AUTHORS: Karen Maria Barlow, MB, ChB, MRCPCH,a,b,c Susan Crawford, MSc,c,d Andrea Stevenson, MSc, MA,e Sandeep Sona Sandhu, BSc,b,e François Belanger, MD, FRCPC,a,d and Deborah Dewey, PhD,a,c,d,g Departments of aPediatrics, cClinical Neurosciences, ePsychology, and gCommunity Health Sciences, University of Calgary, Calgary, Alberta, Canada; dAlberta Children’s Hospital Research Institute for Children and Maternal Health, Calgary, Alberta, Canada; and fBehavioural Research Unit and gDivision of Pediatric Emergency, Department of Pediatrics, Alberta Children’s Hospital, Calgary, Alberta, Canada

KEY WORDS
mild traumatic brain injury, children, cerebral concussion, postconcussion syndrome, epidemiology, outcome

ABBREVIATIONS
ED—emergency department
mTBI—mild traumatic brain injury
PCS—postconcussion syndrome
LOC—loss of consciousness
REDIS—Regional Emergency Department Information System
PCSI—Post Concussion Symptom Inventory
RPQ—Rivermead Postconcussion Symptoms Questionnaire
GFS—General Functioning Scale
FAD—Family Assessment Device
BSI—Brief Symptom Inventory
www.pediatrics.org/cgi/doi/10.1542/peds.2009-0925
doi:10.1542/peds.2009-0925
Accepted for publication Apr 22, 2010
Address correspondence to Karen Maria Barlow, MB, ChB, MRCPCH, Alberta Children's Hospital, C4-335, 2888 Shaganappi Trail NW, Calgary, Alberta, Canada T2B 6A8. E-mail: karen.barlow@albertahealthservices.ca
PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275). Copyright © 2010 by the American Academy of Pediatrics

FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.
Head injuries significant enough to require medical attention in the emergency department (ED) occur in 150 to 400 per 100,000 people, and mild traumatic brain injury (mTBI) accounts for 75% to 85% of these injuries.1,2 Children have the highest incidence of mTBI; in the United States, mTBI occurs in 692 of 100,000 children younger than 15 years.2 Investigators have recently found that mTBI is associated with serious long-term consequences.3 Because 16% of children have had at least 1 head injury requiring medical attention by 10 years of age, mTBI is considered to be a significant public health concern.4 Although there is widespread agreement that mTBI may be associated with significant neuropsychological problems, there is disagreement about whether these problems can be attributed to the brain injury itself.5 Some researchers have suggested that preinjury factors (age, alcohol abuse, education, and neuropsychiatric history), as well as factors that occur after injury (eg, stress and litigation) significantly contribute to the disabilities suffered by patients with mTBI.6,7

Postconcussion syndrome (PCS), the most common entity to be diagnosed in people who have suffered TBI, is a constellation of physical, cognitive, emotional, and behavioral symptoms. The prevalence of PCS after adult mTBI has been reported to vary from 11% to 64% depending on the diagnostic criteria used.8 The International Classification of Diseases, 10th Revision code requires the presence of at least 3 of 8 symptom categories occurring within 1 month of the injury. Criteria of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition require the presence of symptoms in at least 3 of 6 categories for at least 3 months after injury and evidence of neuropsychological dysfunction. The prevalence of persistent symptoms at 1 year is not known but is estimated to be <5%.9 There is limited information on the prevalence and incidence of PCS in children. The few available study reports have included estimations that PCS occurs in 6% to 35% of children after TBI.10,11 Despite the prevalence of PCS, doubt exists about the validity of this diagnosis because behavioral disturbances frequently occur in children after any injury and because factors present before injury and medicolegal concerns after injury may influence recovery.11–15

The purpose of this study was to determine the incidence of PCS after mTBI in children and to characterize the nature of PCS symptoms and document their natural history. We hypothesized that compared with children with ECI, children with mTBI would have a higher incidence of PCS symptoms and that these symptoms would persist longer.

PATIENTS AND METHODS

This study was a prospective, consecutive-cohort epidemiologic study of PCS symptoms after mTBI in children (aged 0–18 years) who were treated at the ED of a tertiary-care children’s hospital with a catchment population of 1.3 million. This study was approved by the University of Calgary Conjoint Health Research Ethics Board.

mTBI Group

mTBI was defined as an admission Glasgow Coma Scale score of 13 to 15, loss of consciousness (LOC) or altered mental state that lasted <20 minutes, absence of focal neurologic deficits, and posttraumatic amnesia that lasted <24 hours.14 The definition of mTBI is somewhat controversial in younger children, in whom it can be difficult to assess an altered mental state and period of amnesia. Therefore, any child with a mild head injury without clear evidence contradicting the above criteria was included in the study. Children with simple scalp lacerations, facial injuries/fractures, or superficial injuries who did not display neurobehavioral change were excluded. mTBI children who had any ECI were also excluded.14

Severity of Concussion

In all patients with mTBI, the concussion injury was categorized according to severity by a neurologist (Dr Barlow), who used the information provided to ED staff regarding LOC, amnesia, and symptoms and signs after the injury. The American Congress of Rehabilitation Medicine criteria for mild traumatic brain injury were used.14,15 Each mTBI was subcategorized on the basis of symptoms, according to a scale of A through F, with equivalent concussion severity grades (Table 1). These subcategories have been used in previous investigations.16,17 Very young children with behavioral change such as “poor feeding” or “fussy” but without classic symptoms of concussion such as headache, vomiting, or LOC were included in category A.

Case Identification

Between November 2005 and January 2008, 78% of children in this urban area seen in EDs with ICD codes for intracranial injuries, including concussion, were seen at this regional ED. The Regional Emergency Department Information System (REDIS) database was used to identify children. The entries categorized as “head injury,” “central nervous system,” “traumatic injury,” or “other” together with the injury descriptions were searched. All REDIS cases were reviewed by a neurologist experienced in TBI (Dr Barlow). The parents of 1264 children with mTBI were contacted 7 to 10 days after injury, and 670 children participated in the study. No differences in age, gender, LOC, or disposition after the ED
TABLE 1 Subcategories of mTBI and the Characteristics of Children in Each Subcategory21

<table>
<thead>
<tr>
<th>mTBI Category</th>
<th>Amnesia</th>
<th>LOC</th>
<th>Symptoms</th>
<th>Neurologic Findings</th>
<th>Concussion Grade</th>
<th>% of Group</th>
<th>Age, Mean (SD), y</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>1</td>
<td>20.2</td>
<td>4.6 (4.7)</td>
</tr>
<tr>
<td>B</td>
<td>No</td>
<td>No</td>
<td>Slight</td>
<td>No</td>
<td>1</td>
<td>18.4</td>
<td>8.2 (5.3)</td>
</tr>
<tr>
<td>C</td>
<td>No</td>
<td>No</td>
<td>Pronounced</td>
<td>Yes</td>
<td>2</td>
<td>29.4</td>
<td>7.5 (5.4)</td>
</tr>
<tr>
<td>D</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td>2</td>
<td>8.4</td>
<td>13.1 (5.6)</td>
</tr>
<tr>
<td>E</td>
<td>1 s–1 min</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td>12.6</td>
<td>10.2 (5.4)</td>
</tr>
<tr>
<td>F</td>
<td>2 s–20 min</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td>4.4</td>
<td>12.6 (4.7)</td>
</tr>
</tbody>
</table>

There was insufficient information for accurate categorization of 6.4% of the children.

- A: Not fully awake and/or focal neurological deficit.
- B: Included infants described as “fussy,” “irritable,” or “poor feeding.”
- C: Slight headache, dizziness, nausea, and/or vomiting.
- D: Not acting like him/herself, where 0 is no difference and 4 is a major difference.
- E: Pronounced symptoms.
- F: Any more points in any symptom was considered clinically significant.

**Measures**

The Post Concussion Symptoms Inventory (PCSI) is a standardized questionnaire that consists of 26 symptoms and provides an overall rating of symptoms based on parent report. It has 6 specific domains: physical, fatigue, cognitive, affective, amnesia, and sleep, and has a high level of internal consistency, \( \alpha = 0.93 \). Individual scores for each symptom (0–4) are obtained. Symptom scores of 3 or 4 were classified as “moderate to severe” symptoms and scores of 0 to 2 as “mild.” A change of 2 or more points in any symptom was considered clinically significant.

The Rivermead Postconcussion Symptoms Questionnaire (RPQ) is a commonly used measure of the severity of symptoms after mTBI, although it does not meet modern psychometric standards.2 This questionnaire addresses 16 postconcussion symptoms that are similar to those addressed in the PCSI. The total and scores on 2 domains (cognitive and emotional-somatic) were calculated.

Children were considered to be symptomatic if parents reported a score of 1 to 4 for the following statement: “In general, to what degree is your child acting differently than before the injury (not acting like him/herself), where 0 is no difference and 4 is a major difference?” and reported that at least 1 symptom showed an increase of 2 or more points on the PCSI.

Symptom resolution was defined as the point at which parents reported no change from before the injury and the scores for all symptoms were back to or below preinjury levels. Time to symptom resolution was calculated as the number of days between the injury and the day after the last telephone contact at which the child was asymptomatic.

The 12-item General Functioning Scale (GFS) of the McMaster Family Assessment Device (FAD) was used as a summary measure of family functioning.

This questionnaire was completed by the mothers of patients 1, 6, and 12 months after injury.

The Brief Symptoms Inventory (BSI) was used to assess maternal psychological adjustment at 1, 6, and 12 months after injury. The BSI is a widely used 53-item, self-report questionnaire of psychiatric symptoms with well-documented reliability and validity.21 It has 2 global measures of psychological symptoms: the mean Global Severity Index which is a sensitive indicator of a respondent’s distress level; and the mean Positive Symptom Distress Index which is a marker of intensity of symptoms.

At enrollment, the parents completed the PCSI. They were first asked to complete the questionnaire in terms of the symptoms the child displayed before the injury (preinjury symptoms) and then complete the questionnaire on the basis of symptoms present during the last few days (postinjury symptoms). If the child was symptomatic, a follow-up telephone call was initiated in 2 weeks and symptoms were reviewed by using the PCSI. Follow-up calls continued at monthly intervals thereafter until symptom resolution.

**Statistical Analysis**

All analyses were performed by using SPSS 17.0 (SPSS Inc, Chicago, IL). Means, SDs, and ranges were used to describe the sample. The Kolmogorov-Smirnov test was used to test for normal distribution of the data. In cases in which data were not normally distributed, nonparametric tests (Pearson’s \( \chi^2 \) test, Mann-Whitney \( U \) test) were used to conduct group comparisons. Effect sizes for Mann-Whitney \( U \) test values were calculated by dividing the obtained \( U \) value by the product of the 2 sample sizes.22 Between-group comparisons of demographic, injury, and past medical details were made by using Pearson \( \chi^2 \) cross-tabulations. For
TABLE 2 Demographic and Injury Characteristics in the mTBI and ECI Groups

<table>
<thead>
<tr>
<th></th>
<th>mTBI (N = 670)</th>
<th>ECI (N = 197)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD), y</td>
<td>&gt;7.62 (5.61)</td>
<td>&gt;9.44 (4.4)</td>
<td>.009</td>
</tr>
<tr>
<td>Range, y</td>
<td>0.01–17.9</td>
<td>0.17–17.79</td>
<td></td>
</tr>
<tr>
<td>Male gender, %</td>
<td>57.5</td>
<td>46.7</td>
<td>.074</td>
</tr>
<tr>
<td>Total family income, median (SD)</td>
<td>$88 960 ($26 385)</td>
<td>$90 570 ($30 235)</td>
<td>.711</td>
</tr>
<tr>
<td>After-tax income, median (SD)</td>
<td>$74 313 ($19 304)</td>
<td>$75 729 ($21 257)</td>
<td>.554</td>
</tr>
<tr>
<td>Admission to hospital, %</td>
<td>6.4</td>
<td>22.4</td>
<td>.002</td>
</tr>
<tr>
<td>LOC, %</td>
<td>10.7</td>
<td>0</td>
<td>.001</td>
</tr>
<tr>
<td>Mechanism of injury, %</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall</td>
<td>51.4</td>
<td>41.6</td>
<td>.045</td>
</tr>
<tr>
<td>Sports related</td>
<td>25.0</td>
<td>44.2</td>
<td>.001</td>
</tr>
<tr>
<td>Unknown</td>
<td>12.5</td>
<td>9.1</td>
<td>.473</td>
</tr>
<tr>
<td>Motor vehicle accident</td>
<td>2.0</td>
<td>2.6</td>
<td>.078</td>
</tr>
<tr>
<td>Assault</td>
<td>1.5</td>
<td>0</td>
<td>.616</td>
</tr>
<tr>
<td>Other</td>
<td>8.0</td>
<td>2.6</td>
<td>.078</td>
</tr>
<tr>
<td>Abbreviated Injury Severity score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>375</td>
<td>197</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>1, %</td>
<td>78.5</td>
<td>62.9</td>
<td></td>
</tr>
<tr>
<td>2, %</td>
<td>20.7</td>
<td>35.3</td>
<td></td>
</tr>
<tr>
<td>3, %</td>
<td>0.8</td>
<td>1.8</td>
<td></td>
</tr>
<tr>
<td>Time after injury of PCSI before injury, median (SD), d</td>
<td>15.85 (11.6)</td>
<td>16.55 (14.7)</td>
<td>.63</td>
</tr>
</tbody>
</table>

* P < .01.
** P < .05.

The demographic and acute-injury details for the mTBI and ECI groups are shown in Table 2. Children in the ECI group were older than those in the mTBI group (P < .001). Falls were associated with older age (P < .001). In the mTBI group LOC was reported in 10.7% of children, and falls were associated with older age (P < .001). A higher proportion of children in the ECI group (22.4% vs 6.4%) were admitted to the hospital (P = .04). The percentages of children lost to follow-up were 13% in the mTBI group and 10% in the ECI group.

RESULTS

The demographic and acute-injury details for the mTBI and ECI groups are shown in Table 2. Children in the ECI group were older than those in the mTBI group (P < .001). Falls were associated with older age (P < .001). In the mTBI group LOC was reported in 10.7% of children, and falls were associated with older age (P < .001). A higher proportion of children in the ECI group (22.4% vs 6.4%) were admitted to the hospital (P = .04). The percentages of children lost to follow-up were 13% in the mTBI group and 10% in the ECI group.

TABLE 3 RPQ and the PCSI Scores in Children With mTBI or ECI 1 and 3 Months After Injury

<table>
<thead>
<tr>
<th>Time After Injury</th>
<th>mTBI Mean (SD)</th>
<th>Range</th>
<th>ECI Mean (SD)</th>
<th>Range</th>
<th>U</th>
<th>P</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 mo (mTBI, n = 670; ECI, n = 197)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCSI total</td>
<td>11.15 (15.09)</td>
<td>0–73</td>
<td>7.62 (10.87)</td>
<td>0–57</td>
<td>17 519.0</td>
<td>.01</td>
<td>0.133</td>
</tr>
<tr>
<td>RPQ total</td>
<td>11.02 (10.65)</td>
<td>0–50</td>
<td>6.09 (7.76)</td>
<td>0–38</td>
<td>8 700.5</td>
<td>&lt;.001</td>
<td>0.184</td>
</tr>
<tr>
<td>Emotional-somatic</td>
<td>9.72 (9.24)</td>
<td>0–42</td>
<td>5.11 (6.30)</td>
<td>0–32</td>
<td>11 650.0</td>
<td>&lt;.001</td>
<td>0.184</td>
</tr>
<tr>
<td>Cognitive</td>
<td>1.80 (2.67)</td>
<td>0–11</td>
<td>.99 (1.92)</td>
<td>0–9</td>
<td>14 472.5</td>
<td>&lt;.001</td>
<td>0.110</td>
</tr>
<tr>
<td>3 mo (mTBI, n = 105; ECI, n = 25)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCSI total</td>
<td>14.25 (18.34)</td>
<td>0–64</td>
<td>5.08 (7.96)</td>
<td>0–32</td>
<td>514.0</td>
<td>&lt;.001</td>
<td>0.196</td>
</tr>
<tr>
<td>RPQ total</td>
<td>13.33 (10.48)</td>
<td>0–41</td>
<td>3.31 (5.10)</td>
<td>0–20</td>
<td>483.5</td>
<td>&lt;.001</td>
<td>0.184</td>
</tr>
<tr>
<td>Emotional-somatic</td>
<td>10.76 (7.94)</td>
<td>0–30</td>
<td>2.75 (4.08)</td>
<td>0–15</td>
<td>460.0</td>
<td>&lt;.001</td>
<td>0.175</td>
</tr>
<tr>
<td>Cognitive</td>
<td>2.50 (3.16)</td>
<td>0–12</td>
<td>.52 (1.26)</td>
<td>0–4</td>
<td>851.0</td>
<td>&lt;.001</td>
<td>0.324</td>
</tr>
</tbody>
</table>

More symptoms were reported for children with mTBI than children with ECI group 1 and 3 months after injury, as demonstrated by higher scores on the RPQ and PCSI.

normally distributed data (ie, FAD, BSI), t tests and analysis of covariance were used to examine group differences. Symptom-free survival was calculated by using Kaplan-Meier log-rank analysis. Participants were censored if they were lost to follow-up, withdrew from the study, or had another injury. Multivariate logistic regression was used to examine associations of age, injury severity, and symptom status.

Symptoms Before Injury

PCSI data on symptoms present before injury were collected 15.85 (SD: 11.6) days after the injury in the mTBI group and 16.55 (SD: 14.7) days after injury in the ECI group (P = .63). Before injury, 56% of children in the mTBI group and 55.4% of children in the ECI group were reported to have at least 1 symptom according to results of the PCSI. The most common moderate-to-severe symptoms reported in the mTBI group were irritability (9%), difficulty falling asleep (8%), and headaches (1%). The most common moderate-to-severe symptoms in the ECI group were irritability (4%), difficulty falling asleep (13%), sensitivity to noise (5%), and headaches (3%). The total symptom scores for symptoms before injury did not differ between groups (P = .98).

Outcome

In the first month after injury, 58.5% and 38.5% of children with mTBI and ECI were symptomatic, respectively (Table 3). As shown in Fig 1, the probability of a child in the mTBI group remaining symptomatic was significantly higher than for a child in the ECI group (log-rank [Mantel-Cox] 11.149; P < .001). If a child with mTBI was symptomatic at 100 days, for example, the child would have a 40% likelihood of remaining symptomatic compared with a 15% likelihood for a child with ECI. Three months after injury, 11% of children were symptomatic in the mTBI group compared with 0.5% in the ECI group. Three months after injury in children older than 6 years, 13.7% of the mTBI group and 1% of the ECI group were symptomatic. The most common symptoms that had increased from before injury to 1 month after injury were “fatigue” (79%), “more emotional” (60%), “irritability” (58%), and head-
aches (58%). The total RPQ scores correlated significantly with the total PCSI scores, $r = .95$, $P < .001$.

The percentage of children who met International Classification of Diseases, 10th Revision criteria for PCS was 82% of those in the mTBI group who were symptomatic 3 months after injury. This result suggests that 9% of all children with mTBI ($n = 60$) had PCS 3 months after injury.

Significant differences were found between groups for the child’s age at injury ($P = .009$). Posthoc comparisons revealed that the asymptomatic mTBI group was younger than the symptomatic mTBI group ($P < .05$). When mTBI severity was considered, the probability that a child would remain symptomatic was significantly associated with the severity of the injury; children with more severe mTBI displayed a significantly higher probability of remaining symptomatic over time (log-rank [Mantel-Cox] = 51.64; $P < .001$) (Fig. 3). Multivariate logistic regression was used to examine the associations between injury severity, age, and symptom status. Results revealed that only injury severity was associated with symptom status (Wald = 5.689; $P = .017$).

Fifteen children with mTBI (2.3%) remained symptomatic for longer than 12 months. In 6 of these children significant premorbid psychological stressors were subsequently diagnosed, and 2 had posttraumatic stress disorder after motor vehicle accident (diagnosed by a psychiatrist). Nine children had chronic posttraumatic headache. In 2 cases further neurologic assessment of the child was refused.

**BSI and FAD**

The initial BSI and FAD responses for each group were compared. The mean GFS on the FAD was similar in both groups; symptomatic mTBI mean = 1.70 (SD: 0.44) and ECI group mean = 1.65 (SD: 0.43) ($P = .55$). The BSI scores did not reveal significant differences between groups: the mean Global Severity Index (a sensitive indicator of respondent’s distress level) was 0.43 (SD: 0.06) in the mTBI group and 0.41...
(SD: 0.10) in the ECI group \((t = 0.12; P = .91)\). The mean Positive Symptom Distress Index was 1.28 (SD: 0.74) in the mTBI group and 1.57 (SD: 0.13) in the ECI group \((t = -1.9; P = .06)\). The time to complete these questionnaires differed between the 2 groups: mTBI, 49 days (SD: 19), and ECI, 21 days (SD: 14), \((t = 7.26, P < .001)\). The inclusion of time as a covariate had no effect on the significance of the above-mentioned findings \((GFS: P = .653; \text{Global Severity Index: } P = .659; \text{Positive Symptom Distress Index: } P = .089)\).

### DISCUSSION

This study was one of the largest detailed, prospective, population-based studies of children after mTBI. The study results demonstrated a definite increase in the duration of PCS symptoms in children with mTBI compared with children with ECI. Eleven percent of children in the mTBI group were symptomatic 3 months after injury compared with 0.5% of the ECI group. This difference was not attributable to group differences in injury status, age, family dysfunction, or maternal adjustment.

Results of a few other studies of children with PCS have revealed an early decrease in functioning that largely resolved by 2 to 3 months after injury. 

Our study results are in keeping with those of a recent study in which investigators observed different trajectories of postconcussive symptoms in children with mTBI compared with children with orthopedic injuries. In addition, our results were similar to those of Ponsford et al, who found that almost 14% of school-aged children with PCS were symptomatic 3 months after injury. The different trajectories of postconcussive symptoms in children with mTBI compared with children with ECI may be attributable to differences in information provided to families after a child suffers an mTBI. At our hospital, all families were given information in the ED about how to monitor their children after a head injury. Therefore, these parents may have expected difficulties and this expectation may have influenced their symptom reports.

One strength of this study relative to many other studies of children with mTBI was that young children were not excluded. Therefore, our results more accurately reflect the population of children with mTBI who are seen in an ED and may show evidence of PCS.

Indeed, we found that older children were more likely to have PCS, although this finding seemed to be largely accounted for by injury severity. Other factors that may account for this difference include the possibility that PCS is age dependent, the higher proportion of young children who presented with minor injuries, the tendency of young children to have symptoms such as poor feeding or being fussy rather than classical PCS symptoms, and the lack of validation for young children of questionnaires used to assess PCS.

It is possible that reporting bias was introduced by the retrospective collection of data on symptoms that were present before injury. We found, however, that symptoms were commonly present before injury in both groups of children. This finding is in keeping with reported findings of other studies, in which PCS symptoms were frequently found in populations of healthy chil-

![FIGURE 3](https://example.com/figure3.png)

**FIGURE 3** Survival curves demonstrating that symptoms are more likely to persist in children older than 6 years (log rank [Mantel-Cox] = 51.64; \(P < .001\)).
children and of children with clinical conditions (eg, chronic pain or depression). Because the usefulness and specificity of PCS as a diagnosis has been debated, we tried to avoid having preconceived ideas about what was required for a diagnosis of PCS. The criteria used to determine whether a child was kept under surveillance were liberal (ie, the parent thought the child was “different” and there was an objective increase in at least 1 symptom). However, we found that 82% of the symptomatic children 3 months after injury had complaints in at least 3 of the 6 symptom domains of the PCSI.

Preexisting factors such as family dysfunction, psychiatric illness, and maternal psychological adjustment have been implicated as important in the persistence of postconcussive symptoms. In our study we found no difference in the BSI and FAD scores between groups. Although in the ECI group the available BSI and FAD data were mostly from children recruited from fracture clinics, early symptoms are not likely to be attributable to differences in maternal psychological adjustment and family dysfunction. This finding is consistent with some recent research results that indicate that family burden and parental adjustment are similar in children with mTBI and control children with orthopedic injuries.

CONCLUSIONS

To our knowledge, this is the first study to report a reliable estimate of the prevalence of PCS symptoms 1 year after injury (2.3%). Therefore, we can reassure children with mTBI and their families that these symptoms are likely to resolve within 12 months after injury. School-aged children with mTBI involving an LOC may have a more protracted course of PCS symptoms. Although long-term outcomes are good, 14% of school-aged children with mTBI have significant morbidity for several months. Provision of proper education and reassurance soon after injury can reduce postconcussive symptoms in adults, but as yet there is strikingly little evidence to guide the management and treatment of PCS in children.

ACKNOWLEDGMENT

This research was supported by a grant from the Alberta Children’s Hospital Foundation.

REFERENCES

3. Thornhill S, Teasdale GM, Murray GD, McCrory P. Prevalence of PCS symptoms in school-aged children 3 months after injury (2.3%). The impact of PCS on school performance and social functioning at this critical time in development is likely to be significant and is worthy of future research.


Epidemiology of Postconcussion Syndrome in Pediatric Mild Traumatic Brain Injury

Karen Maria Barlow, Susan Crawford, Andrea Stevenson, Sandeep Sona Sandhu, François Belanger and Deborah Dewey

*Pediatrics* 2010;126;e374-e381; originally published online Jul 26, 2010; DOI: 10.1542/peds.2009-0925

<table>
<thead>
<tr>
<th>Updated Information</th>
<th>including high-resolution figures, can be found at:</th>
</tr>
</thead>
<tbody>
<tr>
<td>&amp; Services</td>
<td><a href="http://www.pediatrics.org/cgi/content/full/126/2/e374">http://www.pediatrics.org/cgi/content/full/126/2/e374</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>References</th>
<th>This article cites 29 articles, 10 of which you can access for free at:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><a href="http://www.pediatrics.org/cgi/content/full/126/2/e374#BIBL">http://www.pediatrics.org/cgi/content/full/126/2/e374#BIBL</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Permissions &amp; Licensing</th>
<th>Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><a href="http://www.pediatrics.org/misc/Permissions.shtml">http://www.pediatrics.org/misc/Permissions.shtml</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reprints</th>
<th>Information about ordering reprints can be found online:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><a href="http://www.pediatrics.org/misc/reprints.shtml">http://www.pediatrics.org/misc/reprints.shtml</a></td>
</tr>
</tbody>
</table>