

Quality of Life after Brain Injury

Data about sequelae associated with head injuries in patients presenting at a suburban hospital but not hospitalized were collected from [emergency department](#) medical records and two follow-up telephone interviews. During the study period 669 patients with head injuries were discharged from the emergency department. Of these, 288 were asked to participate in the study, 275 (95%) agreed, and 262 (91%) were eventually contacted. Participants and nonparticipants were compared on six variables and differed significantly only on age—younger patients were more likely to be included. Forty-eight hours after trauma, 52% of the respondents suffered headaches, 14% complained of dizziness, and 13% complained of drowsiness. One week after trauma, the complaints were headaches in 27%, dizziness in 11%, and drowsiness in 9%. Twenty-seven per cent had not resumed normal activity at 48 hours after trauma, and 13% had not at 1 week. Sixty-six per cent of the patients followed the patient instructions regarding head injuries ¹⁾.

Neuropsychiatric disturbances

Traumatic brain injury (TBI) causes a wide variety of neuropsychiatric disturbances associated with great functional impairments and low quality of life. These disturbances include disorders of [mood](#), [behavior](#), and [cognition](#), and changes in personality. The diagnosis of specific neuropsychiatric disturbances can be difficult because there is significant symptom overlap. Systematic clinical evaluations are necessary to make the diagnosis and formulate a treatment plan that often requires a multipronged approach. Management of TBI-associated neuropsychiatric disorders should always include nonpharmacological interventions, including education, family involvement, supportive and behavioral psychotherapies, and cognitive rehabilitation. Pharmacological treatments include antidepressants, anticonvulsants, antipsychotics, dopaminergic agents, and cholinesterase inhibitors. However, evidence-based treatments are extremely limited, and management relies on clinical empiricism and resemblance of TBI neuropsychiatric symptom profiles with those of idiopathic psychiatric disorders. Although the understanding of TBI-associated neuropsychiatric disorders has improved in the last decade, further research is needed including prospective, longitudinal studies to explore biomarkers that will assist with management and prognosis as well as randomized-controlled studies to validate pharmacological and nonpharmacological treatments ²⁾.

Return to study

Return to study was relatively successful; however, this was associated with the experience of fatigue and need for far greater effort, assistance and reduced study hours, and somewhat less overall satisfaction ³⁾.

see [QOLIBRI](#)

¹⁾

Coonley-Hoganson R, Sachs N, Desai BT, Whitman S. Sequelae associated with head injuries in patients who were not hospitalized: a follow-up survey. *Neurosurgery*. 1984 Mar;14(3):315-7. PubMed PMID: 6709157.

²⁾

Rao V, Koliatsos V, Ahmed F, Lyketsos C, Kortte K. Neuropsychiatric Disturbances Associated with Traumatic Brain Injury: A Practical Approach to Evaluation and Management. *Semin Neurol*. 2015 Feb;35(1):64-82. Epub 2015 Feb 25. PubMed PMID: 25714869.

3)
Willmott C, Ponsford J, Downing M, Carty M. Frequency and quality of return to study following traumatic brain injury. J Head Trauma Rehabil. 2014 May-Jun;29(3):248-56. doi: 10.1097/HTR.0000000000000014. PubMed PMID: 24413073.

From:
<https://neurosurgerywiki.com/wiki/> - **Neurosurgery Wiki**

Permanent link:
https://neurosurgerywiki.com/wiki/doku.php?id=quality_of_life_after_brain_injury

Last update: **2024/06/07 02:55**

