

Concussion (Mild Traumatic Brain Injury) and the Team Physician: A Consensus Statement—2011 Update

This document is a revision to the team physician consensus statement published in 2006 in *Medicine & Science in Sports & Exercise*® and other publications. Key revisions appearing in this paper include the following:

- No same-day return-to-play (RTP).
- Neurological examination emphasizing cognitive function and balance.
- Role and limitations of neuropsychological (NP) testing.
- Utility of standardized baseline and postinjury assessments.
- Importance of preseason planning.
- Acknowledged importance of cognitive rest.
- Acknowledged emerging technologies and their role in concussion research.
- Recognition of long-term complications of concussion.
- Legislation and governing body regulations for concussion.

DEFINITION

Concussion or mild traumatic brain injury (MTBI) is a pathophysiological process affecting the brain induced by direct or indirect biomechanical forces.

Common features include the following:

- Rapid onset of usually short-lived neurological impairment, which typically resolves spontaneously.
- Acute clinical symptoms that usually reflect a functional disturbance rather than structural injury.
- A range of clinical symptoms that may or may not involve loss of consciousness (LOC).
- Routine neuroimaging studies are typically normal.

GOAL

The goal is to assist the team physician in providing optimal medical care for the athlete with concussion.

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To accomplish this goal, the team physician should have knowledge of and/or be involved with:

- Biomechanics and pathophysiology
- Epidemiology
- Preseason planning and assessment
- Same-day evaluation and treatment
- Post-same-day evaluation and treatment
- Diagnostic testing
- RTP
- Complications of concussion
- Prevention
- Legislative actions

SUMMARY

This document provides an overview of select medical issues that are important to team physicians who are responsible for athletes with concussion. It is not intended as a standard of care and should not be interpreted as such. This document is only a guide and, as such, is of a general nature, consistent with the reasonable, objective practice of the healthcare professional. Individual treatment will turn on the specific facts and circumstances presented to the physician. Adequate insurance should be in place to help protect the physician, the athlete, and the sponsoring organization. This statement was developed by a collaboration of six major professional associations concerned about clinical sports medicine issues; they have committed to forming an ongoing project-based alliance to bring together sports medicine organizations to best serve active people and athletes. These organizations are the American Academy of Family Physicians, the American Academy of Orthopaedic Surgeons, the American College of Sports Medicine, the American Medical Society for Sports Medicine, the American Orthopaedic Society for Sports Medicine, and the American Osteopathic Academy of Sports Medicine.

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INTRODUCTION

It is *essential* the team physician understand:

- The recognition and evaluation of the athlete with concussion.
- After assessment by a health care provider, athletes suspected of or diagnosed with a concussion are removed from practice or competition at that time. There is no same-day RTP, even if the athlete's initial symptoms resolve as the athletic event evolves.
- In the absence of assessment by a health care provider, athletes suspected of concussion are removed from practice or competition, and there is no same-day RTP. There is no subsequent RTP until the athlete is medically cleared by a health care provider.
- Management and treatment of the athlete with concussion be individualized.
 - Concussions are unique to each individual athlete. Symptoms may vary with each concussion an athlete sustains.
- The factors involved in making RTP decisions after injury should be based on clinical judgment in conjunction with individual modifiers known to influence concussion recovery.
- A same-day medical plan specific to concussion injuries be developed.
- The need for documentation.
- While helmet materials and design are improving, there is no concussion-proof helmet.

It is *desirable* the team physician:

- Coordinate a systematic approach for the evaluation and treatment of the athlete with concussion.
- Implement a treatment program.
- Understand the potential sequelae of concussive injuries.
- Understand prevention strategies.
- Educate athletes, parents/guardians, coaches, caregivers, and others.

EPIDEMIOLOGY

- Concussions occur commonly in helmeted and non-helmeted sports and account for a significant number of time loss injuries.
- There are up to of 3.8 million concussions occurring among participants in sports and recreational activities each year.
- Published reports indicate recognized concussion injuries occur frequently.
 - Football, ice hockey, soccer, and lacrosse tend to have the highest concussion incidence rates when calculated by athlete exposure.

- Competition concussion incidence rates are consistently higher than practice rates.
- In sports with the same rules (basketball and soccer), recent research suggests the reported incidence rate of concussion is higher in female athletes.
- The data demonstrating a difference between the reported incidence of concussion in adolescents and adult athletes are inconclusive.
- Self-report and trained observer data suggest significantly higher incidence of concussion.

BIOMECHANICS AND PATHOPHYSIOLOGY

- Concussions occur as a result of imparted linear and rotational accelerations to the brain.
- Because of modifying factors (e.g., concussion history, neck strength, anticipatory reaction and varying magnitudes, frequency, and locations of impact), there is currently no known threshold for concussive injury.
- Metabolic changes that occur in the animal model and thought to occur in humans include the following:
 - Alterations in intracellular/extracellular glutamate, potassium, and calcium.
 - A relative decrease in cerebral blood flow in the setting of an increased requirement for glucose (i.e., increased glycolysis). This mismatch in the metabolic supply and demand may potentially result in cell dysfunction and increase the vulnerability of the cell to a second insult.

PRESEASON PLANNING AND ASSESSMENT

It is *essential* the team physician understand:

- The emergency medical action plan, including guidelines specific to concussion management.

It is *desirable* the team physician:

- Coordinate and be involved with a baseline assessment for high-risk sports and activities.
- Incorporate a standardized baseline assessment tool for concussion that includes prior concussion history, risk factors for prolonged or complicated recovery (Table 1), symptom checklist, and neurological examination emphasizing cognitive function and balance (Appendix 1).

TABLE 1. Risk factors that may prolong or complicate recovery from concussion.

Factors	Modifier
Concussion History	Total number, proximity, severity (duration)
Symptoms	Total number, severity (intensity and especially duration)
Signs	Prolonged LOC (>1 min)
Susceptibility	Concussions occurring with lower impact magnitude and/or requiring longer recovery
Age	Youth and adolescent athletes may recover more slowly
Preexisting conditions	Migraine, depression, anxiety/panic attacks, attention deficit/hyperactivity disorder, learning disabilities

- Coordinate a team for concussion management (e.g., physicians, certified athletic trainers and other health care providers, neuropsychologists, school officials, emergency response personnel).

SAME-DAY EVALUATION AND TREATMENT

It is *essential* the team physician:

- Implement the same-day medical action plan specific to concussion.
- Understand the indications for cervical spine immobilization and emergency transport.

On-Field

- Evaluate the injured athlete on-the-field in a systematic fashion:
 - Assess for adequate airway, breathing, and circulation (ABCs)
 - Perform a focused neurological assessment emphasizing mental status, neurological deficit, and cervical spine status
 - Determine initial disposition (emergency transport vs sideline evaluation)
- There is no RTP on the same day if a concussion is suspected or diagnosed.

Sideline

- Obtain a more detailed history and perform a more detailed physical examination.
 - Assess for cognitive, somatic, and affective signs and symptoms of acute concussion with particular attention paid to the number and severity of symptoms because of their prognostic significance (Table 2).
- The athlete should not be left unsupervised until a disposition decision is made.
- Perform and repeat neurological assessments, with particular emphasis on cognitive function, cranial nerve, and balance testing (32) (Appendix 1).
- Determine disposition for symptomatic and asymptomatic athletes, including postinjury follow-up (options include home with observation or transport to hospital).

- Provide postevent instructions to the athlete and others (e.g., regarding alcohol, medications, physical and cognitive exertion, and medical follow-up).

It is *desirable* the team physician:

On-Field

- Have a plan to protect access to the injured athlete.
- Have emergency medical personnel on-site.
- Have medical supplies on-site for rescue, immobilization, and transportation (1).

Sideline

- Delineate the mechanism of injury.
- Perform a more detailed assessment using a standardized concussion assessment tool (34) (Appendices 1 and 2)
- Coordinate the care and follow-up of the concussed athlete with certified athletic trainers and other health care providers.
- Discuss status of athlete with parents/guardians, caregivers, coaches, and others within disclosure regulations.

POST-SAME-DAY EVALUATION AND TREATMENT

This is the period to monitor for improvement, as well as change in severity or the development of new signs or symptoms (Table 2).

It is *essential* the team physician:

- Obtain a comprehensive history of the current concussion.
 - Brief LOC (seconds, not minutes) is associated with specific early deficits but does not predict the severity of injury; therefore, classification systems or RTP guidelines based solely on brief LOC are not accurate.
 - The number and duration of additional signs and symptoms are more accurate in predicting severity and outcome. RTP guidelines that address these issues are more useful.
 - Duration of symptoms is a major factor in determining severity; therefore, severity of injury should not be determined until all signs and symptoms have cleared.
- Understand risk factors may affect recovery (Table 1).

TABLE 2. Selected acute and delayed signs and symptoms suggestive of concussion.

Cognitive	Somatic	Affective	Sleep Disturbances
Confusion	Headache	Emotional lability	Trouble falling asleep
Anterograde amnesia	Dizziness	Irritability	Sleeping more than usual
Retrograde amnesia	Balance disruption	Fatigue	Sleeping less than usual
LOC	Nausea/vomiting	Anxiety	
Disorientation	Visual disturbances (photophobia, blurry/double vision)	Sadness	
Feeling "in a fog," "zoned out"	Phonophobia		
Vacant stare			
Inability to focus			
Delayed verbal and motor responses			
Slurred/incoherent speech			
Excessive drowsiness			

- Perform a neurological examination with particular emphasis on cognitive function, cranial nerve, and balance testing.
- Determine the need for further evaluation and consultation.
- Understand the role and limitations of NP testing.
- Determine RTP status. The treatment of and the RTP decision for the athlete with concussion must be individualized.

It is *desirable* the team physician:

- Coordinate the care and follow-up of the athlete.
- Compare findings to standardized baseline assessment.
- Educate the athlete, parents/guardians, caregivers, and others about concussion.
- Coordinate the care and follow-up of the concussed athlete with certified athletic trainers and other health care providers.
- Discuss status of athlete with parents/guardians, caregivers, coaches, and others within disclosure regulations.
- Work in collaboration with the neuropsychologist to interpret NP testing.

DIAGNOSTIC TESTING

Imaging

It is *essential* the team physician understand:

- The limited value of plain skull radiographs, head computed tomography, or magnetic resonance imaging for concussion.
- Indications for head computed tomography or magnetic resonance imaging (e.g., decreasing level of consciousness, increasing severity of signs and symptoms, persistent focal neurologic deficit) to assess associated injuries including intracranial bleed, cerebral edema, diffuse axonal injury, and/or skull fracture.
- Indications for the use of cervical imaging when cervical spine injury is suspected.

It is *desirable* the team physician:

- Review the results of the imaging studies.
- Recognize that advanced testing, such as functional magnetic resonance imaging, diffusion tensor imaging, and magnetic resonance spectroscopy, represents research tools that may one day be clinically applicable.

NP Testing

It is *essential* the team physician understand:

- NP testing is recommended as an aid to clinical decision-making but not a requirement for concussion management.
- NP testing is one component of the evaluation process and should not be used as a stand-alone tool to diagnose, manage or make RTP decisions in concussion.

It is *desirable* the team physician understand:

- The indications and limitations of NP testing.
 - Postinjury NP test data are more useful if compared to the athlete's preinjury baseline.
 - It is unclear what type and content of test data are most valid and valuable.
- Value of NP testing is enhanced when used as part of a multifaceted assessment and treatment program.

Additional Tests

Biomarkers

- Investigation in the area of biomarkers (e.g., S-100 proteins, neuron specific enolase, tau protein) is inconclusive for identifying individuals with concussion and represents research that may one day be clinically applicable.

Event- and evoke-related potentials

- Electrophysiologic research using event- and evoke-related potentials is inconclusive for the clinical management of concussion at this time and represents research that may one day be clinically applicable.

RTP DECISION

The RTP decision should be individualized and not based on a rigid timeline. The team physician is ultimately responsible for the RTP decision (1).

Same-Day RTP

It is *essential* the team physician understand:

- There is no same-day RTP for the concussed athlete.

Post-Same-Day RTP

It is *essential* the team physician understand:

- Before resuming exercise, the athlete must be asymptomatic or returned to baseline symptoms at rest and has no symptoms with cognitive effort.
 - Amnesia surrounding the event may be permanent.
- An athlete should no longer be taking medications that may mask or modify concussion symptoms.
- The athlete's clinical neurological examination (cognitive, cranial nerve, and balance testing) have returned to baseline before resuming exercise.
- If performed, NP testing returns to at-least baseline before resuming contact/collision activities.
- Progressive aerobic and resistance exercise challenge tests should be utilized before full RTP (27,34).
 - This process may take days, weeks, or months.
 - Recurrence of symptoms and/or signs warrants additional rest and monitoring.

- Certain risk factors may affect RTP decision making (Table 1).
- Additional factors may affect RTP decision making:
 - Risk-taking behaviors
 - Type of sport

It is *desirable* the team physician:

- Coordinate a team to implement sport-specific progressive aerobic and resistance exercise challenge tests before full RTP.
- Facilitate academic accommodations for symptomatic student athletes.
- Discuss status of athlete with parents/guardians, caregivers, certified athletic trainers, coaches, school officials, and others within disclosure regulations.

COMPLICATIONS OF CONCUSSION

Concussion may cause a wide range of short- or long-term complications, affecting thinking, sensation, language, or emotions. These changes may lead to problems with memory, communication, personality changes, as well as depression and the early onset of dementia. Other complications of concussion are also addressed in this section.

- Prior concussions may increase risk for subsequent concussions.
- Postconcussion syndrome
 - Persistent postconcussion symptoms lasting 3 months or longer
 - Indicator of concussion severity
 - Precludes RTP while present
 - Increased risk of depression
- Convulsive motor phenomena
 - Tonic posturing or convulsive movements within seconds of the concussion
 - Dramatic, but usually benign
 - Require no management beyond on-field ABCs
 - No anticonvulsant therapy required
- Posttraumatic seizures
 - Seizures occur days to months after concussion
 - Does require seizure management and precautions
 - Usually requires anticonvulsant therapy
- Second-impact syndrome
 - Occurs within minutes of concussion in athlete still symptomatic from prior brain injury, which can be earlier in same event.
 - Vascular engorgement leads to massive increase in intracranial pressure and brain herniation resulting in severe brain damage or death.
 - May occur with associated small subdural hematoma.
 - Except for boxing, most cases in literature in adolescents.
- Chronic traumatic encephalopathy
 - A progressive neurodegenerative disease (tauopathy) caused by total brain trauma, and is not limited to athletes who have reported concussions.

- The incidence and prevalence is unknown.
- Diagnosed only after death by distinctive immunoreactive stains of the brain for tau protein and is not the same disease as Alzheimer.
- Typical signs and symptoms include a decline of recent memory and executive function, mood, and behavioral disturbances (especially depression, impulsivity, aggressiveness, anger, irritability, suicidal behavior, and eventual progression to dementia).
- Initial signs and symptoms do not typically manifest until decades after trauma received (ages 40–50 yr).
- A small subset of individuals with chronic traumatic encephalopathy have developed chronic traumatic encephalomyopathy, a progressive motor neuron disease characterized by profound weakness, atrophy, spasticity, and fasciculation similar to amyotrophic lateral sclerosis.
- Depression
 - Increased risk after a history of multiple concussions
 - May predate concussion and/or occur independent of concussion.
 - Athletes with depression who later sustain concussion may experience worsening symptoms.
- Mild cognitive impairment
 - Increased risk later in life after a history of multiple concussions.
 - May predate concussion and/or occur independent of concussion.
 - Multiple concussions have been associated with an earlier onset of mild cognitive impairment.

It is *essential* the team physician understand:

- Short- and long-term complications of concussion may be life threatening or life altering.
- Proper management may mitigate concussion complications such as second-impact syndrome and postconcussion syndrome.

It is *desirable* the team physician:

- Counsel the athlete about the significance of the long-term consequences of concussion, especially recurrent concussion.
- Facilitate assessment and treatment of complications.
- Discuss status of athlete with parents/guardians, caregivers, certified athletic trainers and coaches, and others within disclosure regulations.

PREVENTION

Concussions cannot be completely prevented.

It is *essential* the team physician understand:

- Helmets do not prevent concussion, although they decrease the incidence of skull fracture and major head trauma.
- There is currently no evidence to support the use of other personal protective equipment to prevent concussion and

their use for this purpose may create a false sense of security.

- Mouth guards decrease risk of dental or oral injury.
- Head gear for soccer, rugby, wrestling, and boxing may decrease risk of lacerations and soft tissue trauma.
- Improper use of the head and improper fit of helmet or protective equipment may increase the risk of concussion.
- There are rules that prohibit hits to the head and other conduct that may decrease the incidence of concussion (e.g., spearing, head-to-head contact, leading with the head).

It is *desirable* the team physician:

- Educate athletes, parents/guardians, and coaches regarding the significance of concussion, specifically to:
 - Understand short- and long-term health consequences
 - Recognize and report signs and symptoms of concussive injury
 - Understand earlier medical assessment and management promotes recovery
- Work with coaches and administrators to implement a concussion prevention program and policy, with emphasis on the importance of reporting concussion.
- Discuss the enforcement of rules to limit concussion with coaching staff, athletes, and officials before practice and competition.

- Discuss with athletes and coaches techniques that may increase the risk of concussion.
- Promote a safe playing environment that may lower the risk of head injury (e.g., field conditions, soccer goals, pole vault landing pits).
- Work with coaches, athletes, and parents to change the culture of intentional acts of unsportsmanlike conduct that causes injury.

LEGISLATION AND GOVERNANCE ISSUES

Many states have passed laws regarding concussion, and governing bodies have adopted rule changes and developed guidelines. The team physician is affected by legislation and governance issues both administratively and clinically.

It is *essential* the team physician understand:

- The laws of the state in which he or she is practicing regarding concussion.
- Rules and regulations from governing bodies regarding concussion.

It is *desirable* the team physician:

- Participate with state athletic associations in advocacy (interscholastic associations).
- Participate in the education of the athlete, parents/guardians, caregivers, and others.



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SELECTED READINGS

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APPENDIX 1: NFL SIDELINE TOOL – BASELINE



This tool does not constitute, and is not intended to constitute, a standard of medical care. It is a guide derived from the Standardized Concussion Assessment Tool 2 (SCAT2) (McCrory, et al, BJSM '09) and represents a standardized method of evaluating NFL players for concussion consistent with the reasonable, objective practice of the healthcare profession. This guide is not intended to be a substitute for the clinical judgment of the treating healthcare professional and should be interpreted based on the individual needs of the patient and the specific facts and circumstances presented.

NFL Sideline Concussion Assessment Tool: BASELINE TEST. Athlete completes blue sections. ATC/MD/DO completes sheet.

Athlete _____ Position _____ Team _____ Athlete Initials _____

Date & Time of Baseline Test: Date _____ Time _____ am / pm Evaluator _____ ATC / MD / DO / Other _____

RISK FACTORS:**Concussion History**

Have you EVER had a concussion, had your "bell rung", or had any of the symptoms below as a result of a head injury? Y N

If yes, previous number 0 1 2 3 4 5 6+

What type of symptoms did you have? _____

How long were you out of activity? _____

Have you ever lost consciousness as a result of a head injury? Y N If yes, how long? _____

Have you ever been hospitalized as a result of a head injury? Y N Details _____

Have you ever had any imaging tests of your brain (CT, MRI, DTI, other)? Y N Details _____

Date of most recent concussion? _____

Additional Risk Factors: Personal History

Have you ever been diagnosed with:

- ☐ Headache or migraines?
☐ Learning disability / dyslexia?
☐ ADD / ADHD?
☐ Depression, anxiety or other psychiatric disorder?
☐ Seizure disorder?

Are you on any medications? If yes please list _____

Family History

Has anyone in your family ever been diagnosed with:

- ☐ Headache or migraines?
☐ Learning disability / dyslexia
☐ ADD / ADHD
☐ Depression, anxiety or other psychiatric disorder?
☐ Seizure disorder?

How do you feel? The athlete should score themselves on the following symptoms, based on how they feel at the time.

(i.e. 0 = not present, 1 = mild, 3 = moderate, 6 = severe)

Headache / head pressure	0 1 2 3 4 5 6	Feeling slowed down	0 1 2 3 4 5 6
Nausea / vomiting	0 1 2 3 4 5 6	Sensitivity to noise	0 1 2 3 4 5 6
Neck pain	0 1 2 3 4 5 6	Sensitivity to light	0 1 2 3 4 5 6
Drowsiness	0 1 2 3 4 5 6	Visual problems /blurred vision	0 1 2 3 4 5 6
Balance problems	0 1 2 3 4 5 6	Sleeping more than usual	0 1 2 3 4 5 6
Dizziness	0 1 2 3 4 5 6	Sleeping less than usual	0 1 2 3 4 5 6
Fatigue / low energy	0 1 2 3 4 5 6	Trouble falling asleep	0 1 2 3 4 5 6
Confusion	0 1 2 3 4 5 6	Sadness	0 1 2 3 4 5 6
"Don't feel right"	0 1 2 3 4 5 6	Nervous or anxious	0 1 2 3 4 5 6
Feeling "in a fog"	0 1 2 3 4 5 6	Feeling more emotional	0 1 2 3 4 5 6
Difficulty remembering	0 1 2 3 4 5 6	Irritability	0 1 2 3 4 5 6
Difficulty concentrating	0 1 2 3 4 5 6	Numbness or tingling	0 1 2 3 4 5 6

Total # Symptoms: of 24 = _____ Symptom Severity Score: (max 24 symptoms X max 6 rating) of 144 = _____

Athlete should initial in upper right hand corner that information provided above is accurate to the best of their knowledge
BELOW IS FOR ATC / MD / DO / OTHER PROVIDER USE ONLY

Select Physical Signs or Symptoms: Screen for Cervical Spine and/or More Serious Brain Trauma

Any reported neck pain, c-spine tenderness or decreased range of motion?	Y	N
Pupil reaction abnormal or pupils unequal ?	Y	N
Extra-ocular movements abnormal and/or cause double vision?	Y	N
Asymmetry or abnormalities on screening motor or sensory exam?	Y	N
Other _____		

APPENDIX 1: CONTINUED



NFL Sideline Concussion Assessment Tool: BASELINE TEST (continued)

ORIENTATION / SAC

of 5 = ____

What month is it?	0	1
What is the date today?	0	1
What is the day of the week?	0	1
What year is it?	0	1
What time is it right now? (within an hour)	0	1

SAC / Word Recall: Read list of 5 words 1 per second, ask athlete to repeat list, in any order. (Use of specific lists below optional) For Trial 2 & 3, read the same list of words again and have athlete repeat them back, in any order. One point for each word remembered. You must conduct all 3 trials regardless of their success on trial 1. **Do not tell athlete that delayed recall will be tested**

List 1	Immediate Recall Trials			Alternative Lists		Delayed recall (perform at end of all sideline testing, at least > 5 minutes)
	#1	#2	#3			
elbow	_____	_____	_____	candle	baby	_____
apple	_____	_____	_____	paper	monkey	_____
carpet	_____	_____	_____	sugar	perfume	_____
saddle	_____	_____	_____	sandwich	sunset	_____
bubble	_____	_____	_____	wagon	iron	_____

Total of all three immediate word recalls: out of 15 = ____

Total delayed recall: out of 5 = ____

SAC / Concentration: Read string of numbers, ask athlete to repeat backwards. (Use of specific numbers below optional). If correct go to the next string length. If incorrect, read second string (same length) 1 point for each string length correct. Stop after incorrect on both trials. Read digits at rate of 1 digit /sec

Digits Backward:**Alternative digit lists**

4-9-3	0	1	6-2-9	5-2-6
3-8-1-4	0	1	3-2-7-9	1-7-9-5
6-2-9-7-1	0	1	1-5-2-8-6	3-8-5-2-7
7-1-8-4-6-2	0	1	5-3-9-1-4-8	8-3-1-9-6-4

SAC / Concentration cont. Months in reverse order

Dec - Nov - Oct - Sept - Aug - Jul - Jun - May - Apr - Mar - Feb - Jan

1 point for months in reverse correctly (< 30 sec) = ____

1 point for each sequence correct of 4 = ____

Total of SAC Concentration of 5 = ____

Modified BESS: This is calculated by adding 1 error point for each error during the three 20-sec tests. The maximum total # of errors for any single condition is 10. The higher the score, the worse is the player's balance.

Balance testing – types of errors

1. Hands lifted off iliac crest
2. Opening eyes
3. Step, stumble, or fall
4. Moving hip into > 30 degrees abduction
5. Lifting forefoot or heel
6. Remaining out of test position > 5 sec

Which foot tested (non-dominant foot) ☐ L ☐ R

Double leg stance (feet together) # errors ____

Single leg stance (non dominant foot) # errors ____

Tandem stance (non dominant foot at back) # errors ____

BALANCE SCORE: (summed # of errors)= ____**SCORING:**

All SAC scores (summed orange boxes) = ____ of 30

BALANCE Score: (summed BESS Errors) = ____

Symptom Score: (# symptoms reported) = ____ of 24

ADDITIONAL COMMENTS: _____

APPENDIX 2: NFL SIDELINE TOOL – POST-INJURY



This tool does not constitute, and is not intended to constitute, a standard of medical care. It is a guide derived from the Standardized Concussion Assessment Tool 2 (SCAT2) (McCrory, et al, BJSM '09) and represents a standardized method of evaluating NFL players for concussion consistent with the reasonable, objective practice of the healthcare profession. This guide is not intended to be a substitute for the clinical judgment of the treating healthcare professional and should be interpreted based on the individual needs of the patient and the specific facts and circumstances presented.

NFL Sideline Concussion Assessment Tool : Completed by healthcare professional. Athlete completes symptoms at bottom.

Athlete _____ Position _____ Team _____ Evaluator _____ ATC / MD / DO

Evaluation date _____ time _____ am / pm Injury date _____ time _____ am / pm during ☐ Game ☐ Practice ☐ Other _____

Mechanism of injury ☐ head to head ☐ elbow to head ☐ knee to head ☐ ground to head ☐ blow to body

☐ other mechanism _____ ☐ unknown mechanism

Penalty called ☐ Yes ☐ No Other circumstances _____

This concussion assessment tool contains an assessment of orientation, memory, concentration, balance & symptoms. This tool is intended to be used in conjunction with your clinical judgment. If **ANY** significant abnormality is found, a conservative, "safety first" approach should be adopted. An athlete suspected of sustaining a concussion is a "No Go" and does not return to play in the same game or practice.

ANY OF THE FOLLOWING ARE OBVIOUS SIGNS OF DISQUALIFICATION (i.e. "No Go"):

- | | | | |
|---|--------------------------|---|---|
| 1) LOC or unresponsiveness? (for any period of time) If so, how long? _____ | <input type="checkbox"/> | Y | N |
| 2) Confusion? (any disorientation or inability to respond appropriately to questions) | <input type="checkbox"/> | Y | N |
| 3) Amnesia (retrograde / anterograde)? If so, how long? _____ | <input type="checkbox"/> | Y | N |
| 4) New and/or persistent symptoms: see checklist? (e.g. headache, nausea, dizziness) | <input type="checkbox"/> | Y | N |
| 5) Abnormal neurological finding? (any motor, sensory, cranial nerve, balance issues, seizures) or | <input type="checkbox"/> | Y | N |
| 6) Progressive, persistent or worsening symptoms? If so, consider cervical spine and/or a more serious brain injury (See box below) | <input type="checkbox"/> | Y | N |
| Other _____ Total Physical Signs Score: (total above <input type="checkbox"/> Yes scores) of 6= _____ | | | |

Neurological Screen for Cervical Spine and/or More Serious Brain Trauma

- | | | |
|--|---|---|
| Deteriorating mental status? | Y | N |
| Any reported neck pain, cervical spine tenderness or decreased range of motion? | Y | N |
| Pupil reaction abnormal or pupils unequal? | Y | N |
| Extra-ocular movements abnormal and/or cause double vision? (difficulty tracking and/or reading) | Y | N |
| Asymmetry or abnormalities on screening motor sensory exam? | Y | N |

ORIENTATION / SAC

of 5 = _____

- | | | |
|---|---|---|
| What month is it? | 0 | 1 |
| What is the date today? | 0 | 1 |
| What is the day of the week? | 0 | 1 |
| What year is it? | 0 | 1 |
| What time is it right now? (within an hour) | 0 | 1 |

ORIENTATION / Maddock's Questions of 5 = _____

- | | | |
|---|---|---|
| Where are we? | 0 | 1 |
| What quarter is it right now? | 0 | 1 |
| Who scored last in the practice / game? | 0 | 1 |
| Who did we play last game? | 0 | 1 |
| Did we win the last game? | 0 | 1 |

SAC / Word Recall: Read list of 5 words 1 per second, ask athlete to repeat list, in any order. (Use of specific lists below optional). For Trial 2 & 3, read the same list of words again and have athlete repeat them back, in any order. One point for each word remembered. You must conduct all 3 trials regardless of their success on trial 1. **Do not tell athlete that delayed recall will be tested**

List 1 Immediate Recall Trials

- | | #1 | #2 | #3 |
|--------|-------|-------|-------|
| elbow | _____ | _____ | _____ |
| apple | _____ | _____ | _____ |
| carpet | _____ | _____ | _____ |
| saddle | _____ | _____ | _____ |
| bubble | _____ | _____ | _____ |

Alternative Lists

- | | |
|----------|---------|
| candle | baby |
| paper | monkey |
| sugar | perfume |
| sandwich | sunset |
| wagon | iron |

Delayed recall (perform at end of all sideline testing, at least > 5 minutes)

- | |
|-------|
| _____ |
| _____ |
| _____ |
| _____ |
| _____ |

Total of all three immediate word recalls: out of 15 = _____

Total delayed recall: out of 5 = _____

APPENDIX 2: CONTINUED



NFL Sideline Concussion Assessment Tool (continued)

Overall Rating; If you know the athlete well p/t the injury, how different is the athlete acting compared to his usual self?

Check one; ☐ No different ☐ Very different ☐ Unsure

SAC / Concentration: Read string of numbers, ask athlete to repeat backwards. (Use of specific numbers below optional). If correct go to the next string length. If incorrect, read second string (same length) 1 point for each string length correct. Stop after incorrect on both trials. Read digits at rate of 1 digit /sec

Digits Backward: **Alternative digit lists**
 4-9-3 0 1 6-2-9 5-2-6
 3-8-1-4 0 1 3-2-7-9 1-7-9-5
 6-2-9-7-1 0 1 1-5-2-8-6 3-8-5-2-7
 7-1-8-4-6-2 0 1 5-3-9-1-4-8 8-3-1-9-6-4

1 point for each sequence correct of 4 = _____

SAC / Concentration cont. Months in reverse order
 Dec - Nov - Oct - Sept - Aug - Jul - Jun - May - Apr - Mar - Feb - Jan

1 point for months in reverse correctly (<30 sec) = _____

Total of SAC Concentration of 5 = _____

Modified BESS: This is calculated by adding 1 error point for each error during the three 20-sec tests. The maximum total # of errors for any single condition is 10. The higher the score, the worse is the player's balance.

Balance testing – types of errors

1. Hands lifted off iliac crest
2. Opening eyes
3. Step, stumble, or fall
4. Moving hip into > 30 degrees abduction
5. Lifting forefoot or heel
6. Remaining out of test position > 5 sec

Which foot tested (non-dominant foot) ☐ L ☐ R

Double leg stance (feet together) # errors _____

Single leg stance (non dominant foot) # errors _____

Tandem stance (non dominant foot at back) # errors _____

BALANCE SCORE: (summed # of errors) = _____

Signs and symptoms of concussion may be delayed, and therefore it may be prudent to remove an athlete from play, not leave them alone, and serially monitor them over a period of time. **WHEN IN DOUBT, TAKE A "TIME OUT"**

SCORING

All Physical Signs Score: (total # ☐ Yes) = _____ of 6

Maddock's score: = _____ of 5

All SAC scores: (summed orange boxes) = _____ of 30

Balance Score: (summed BESS Errors) = _____

Symptom Score: (# symptoms reported) = _____ of 24

ALL SCORES SHOULD BE COMPARED WITH BASELINE VALUES FOR THE INDIVIDUAL ATHLETE

The following symptom checklist should be completed by the athlete

How do you feel? The athlete should score themselves on the following symptoms, as applicable, based on how they feel at the time. (i.e. 0 = not present, 1 = mild, 3 = moderate, 6 = severe)

Headache / head pressure	0 1 2 3 4 5 6	Feeling slowed down	0 1 2 3 4 5 6
Nausea / vomiting	0 1 2 3 4 5 6	Sensitivity to noise	0 1 2 3 4 5 6
Neck pain	0 1 2 3 4 5 6	Sensitivity to light	0 1 2 3 4 5 6
Drowsiness	0 1 2 3 4 5 6	Visual problems/ blurred vision	0 1 2 3 4 5 6
Balance problems	0 1 2 3 4 5 6	Sleeping more than usual	0 1 2 3 4 5 6
Dizziness	0 1 2 3 4 5 6	Sleeping less than usual	0 1 2 3 4 5 6
Fatigue / low energy	0 1 2 3 4 5 6	Trouble falling asleep	0 1 2 3 4 5 6
Confusion	0 1 2 3 4 5 6	Sadness	0 1 2 3 4 5 6
"Don't feel right"	0 1 2 3 4 5 6	Nervous or anxious	0 1 2 3 4 5 6
Feeling "in a fog"	0 1 2 3 4 5 6	Feeling more emotional	0 1 2 3 4 5 6
Difficulty remembering	0 1 2 3 4 5 6	Irritability	0 1 2 3 4 5 6
Difficulty concentrating	0 1 2 3 4 5 6	Numbness or tingling	0 1 2 3 4 5 6

Do symptoms worsen with physical activity? Y N

Do symptoms worsen with mental activity? Y N

Total # symptoms = _____ of 24

Symptom Severity (max 24 X max 6) = _____ of 144