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Management of persistent postconcussion symptoms in youth: a randomised control trial protocol

Nick Reed, Dayna Greenspoon, Grant L Iverson, Carol DeMatteo, Philippe Fait, Jérôme Gauvin-Lepage, Anne Hunt, Isabelle J Gagnon

ABSTRACT

Introduction: Current management of concussion consists of early education, rest until symptom free, with gradual return to school and physical activity protocols. Although this management strategy is effective for most youth who sustain a concussion, it is not an appropriate strategy for youth with persistent postconcussion symptoms. Prolonged rest and periods of restricted activity may place youth at risk for secondary issues and contribute to the chronicity of postconcussion symptoms. The purpose of this study is to evaluate the efficacy of an active rehabilitation protocol for youth who are slow to recover from concussion. It is hypothesised that an active rehabilitation intervention can reduce persistent postconcussion symptoms, improve function and facilitate return to activity. This article describes the research protocol.

Methods and analysis: This is a randomised clinical trial with blinded outcome measurement. Participants will be recruited and randomly assigned to 1 of 2 treatment groups, an active rehabilitation intervention or a standard care education group. Both groups will receive standard care education. However, the active rehabilitation group will participate in an additional low-intensity exercise programme consisting of aerobic, coordination and visualisation exercises. Both the active rehabilitation and the standard care education interventions will be 6 weeks in duration. The primary outcome measure is postconcussion symptoms. Secondary outcome measures include functional recovery (cognitive, motor, psychosocial and emotional functioning) and return to activity. Outcome measures will be administered preintervention and postintervention. The primary outcome measure will also be repeated 2 weeks into the intervention period.

Ethics and dissemination: This study has been approved by the Holland Bloorview Kids Rehabilitation Hospital research ethics board (REB # 13-459). The findings from this study will be shared with the general public, sport associations, relevant brain injury organisations and healthcare professionals.

Trial registration number: NCT02257749.

INTRODUCTION

According to International Consensus, concussion is defined as “A complex pathophysiological process affecting the brain, induced by biomechanical forces” (ref. 1, p.89). The acute management of concussion in children and youth includes early identification, education and reassurance, along with physical and cognitive rest. Return to school, often with accommodations, often occurs while the youth is symptomatic—and some clinician-researchers have provided recommendations for this. After postconcussion symptoms resolve, graduated return-to-play protocols are followed. International Consensus suggests that for most, recovery from a concussion is a short-lived process (80–90% experience symptom resolution within 7–10 days). However, there remains a percentage of individuals who will experience persisting symptoms and will need additional care and rehabilitation. Further, it has been suggested that children and youth are more susceptible to prolonged recovery. An epidemiological study exploring postconcussion symptoms among children found that 58.5% of children remained symptomatic in the first month following concussion, 11% at 3 months, and 2.3% beyond 1 year. As a result, a significant number of youth who experience a concussion will suffer from persistent symptoms. To date, little is known about interventions to manage these youth and the research to date exploring approaches to rehabilitation specific to youth with persistent symptoms has been limited to case reports and descriptions. This study aims to address this gap by investigating two treatment approaches for youth who continue to experience symptoms lasting 1-month or longer following their concussion and applies a randomised control trial protocol.
design to improve the methodological quality of the evidence, which might then justify improved approaches to rehabilitation within this population.

Prolonged rest and extended periods of activity restriction may place youth at risk for secondary issues (eg, physical deconditioning, irritability, anxiety, stress and depression) and may contribute to symptom maintenance over time. A further consideration is that for many youth, absolute rest is unrealistic, and youth will naturally transition back to an active lifestyle, especially those who are only mildly symptomatic. Complicating these issues is that little is known about the optimal time period for rest and activity restriction following concussion. It is possible that extended periods of rest and activity restrictions contribute to the development of secondary problems including emotional consequences. Unfortunately, the authors of a systematic review examining treatment for sports-related concussions found that the literature regarding treatment approaches is severely lacking.

Regular exercise has been shown to have positive effects on well-being including mental health, improved self-esteem, sleep and memory. It is also known to promote neuroplasticity and neurogenesis in healthy and injured brains. Leddy et al used supervised exercise protocols with adults who experienced a concussion and were suffering from persistent postconcussion symptoms. Using a carefully controlled progressive programme where participants exercised on a treadmill 5–6 days per week at 80% of a predetermined symptom exacerbation threshold during exercise, participants showed significant decreases in postconcussive symptoms and recovery time.

Recognising the promising nature of exercise as an approach to rehabilitation, Gagnon et al published a case series examining the outcome of an active rehabilitation programme on 16 children and adolescents with persistent postconcussion symptoms. The active rehabilitation programme consists of a combination of submaximal aerobic training, light sport-specific coordination exercises, visualisation and imagery techniques, and a home exercise programme. All youth had a decrease in their postconcussion symptoms, and successfully returned to their activities of daily living including sports participation following the intervention. Youth reported high satisfaction with the intervention and findings from a qualitative analysis suggest an improved sense of empowerment for youth and their parents. In a second case series of 10 adolescents with persistent symptoms, postconcussive symptoms and functioning improved after participation in the active rehabilitation intervention, suggesting that the introduction of graded light-intensity exercise in the postacute period following concussion is feasible and appears to have positive benefits in uncontrolled studies.

Overall, the current literature examining exercise as a treatment modality postconcussion, and in particular, persistent postconcussion symptoms, appears positive. However, this body of literature is very limited in quantity and quality, lacking randomisation and comparison groups. As such, the most recent consensus statement on concussion in sport from the 4th International Conference on Concussion in Sport Consensus Conference (2013) advocates more research on the effectiveness of these approaches in order to best meet the needs of the individuals following a concussion. This study aims to address these gaps and meet this call from the concussion clinical and research community.

The purpose of this randomised clinical trial is to examine the efficacy of an active rehabilitation protocol as compared with a standard care comprehensive education protocol for treatment of youth with persistent postconcussion symptoms (greater than 1 month postinjury). This study expands on the work of Gagnon et al by implementing a more rigorous study methodology using a two-group, prospective, randomised control design. This study examines whether a 6-week active rehabilitation programme in combination with standard care comprehensive education is more effective in reducing postconcussive symptoms and improving functional recovery than standard care comprehensive education alone. The study objective is to determine the efficacy of the active rehabilitation programme, compared with standard care alone, with respect to (1) reduction in postconcussive symptoms and (2) functional recovery as indicated by cognitive, motor and psychological measures. This paper presents the protocol used for this study.

METHODS
Design
This study will examine the effects of an adapted form of the active rehabilitation protocol reported by Gagnon and colleagues with youth who continue to experience symptoms for more than 1 month following concussion. A two-group prospective randomised design that includes blinded outcome assessment will be used. Following a telephone screening interview, participants will attend a baseline testing session and be randomised to the experimental (active rehabilitation plus standard care comprehensive education) or control group (standard care comprehensive education). Participants will be told that they are receiving one of two interventions for concussion management. Table 1 presents a summary of the study procedure. All study procedures will be conducted at a paediatric rehabilitation hospital in Toronto, Canada.

Participants and recruitment
One hundred youth with persistent symptoms for at least 1 month following concussion will be recruited. Participants will be recruited via (1) referrals from our facility’s concussion clinic; and (2) flyers sent to local community practitioners (eg, family physicians, paediatricians, etc). All recruitment materials will direct interested potential participants (and their families) to contact the study coordinator to learn more. Potential
participants will be screened by a telephone interview to determine eligibility. Inclusion criteria are youth between the ages of 10 and 18 years with a confirmed diagnosis of mild traumatic brain injury (mTBI) or concussion; concussive injury that occurred between 1 and 3 months prior to enrolment in the study; presence of at least one postconcussion symptom as measured by the Post-Concussion Symptom Inventory (PCSI)23 (eg, headaches, anxiety, fatigue) for greater than 4 weeks; fluent in written and spoken English and; able to demonstrate capacity to consent to participate in the study. To be enrolled, the child or adolescent must have at least one symptom that is believed to be related to the injury and has resulted in the youth not being medically cleared to fully return to sports or other recreational activities. Exclusion criteria include youth with more than one concussion in the past 6 months; presence of neck pain; presence of significant musculoskeletal pain or balance dysfunction; pre-existing comorbidities (eg, chronic pain, cardiac, mental health or autoimmune conditions) that prevent participation in active rehabilitation, assessment of gait or balance, or participation in cognitive testing; concurrent participation in other physical rehabilitation interventions for persisting postconcussion symptoms (eg, physiotherapy, massage therapy, chiropractic) at the time of enrolment and throughout the duration of the study.

Informed consent
This trial is registered with clinicaltrials.gov, registration #: NCT02257749. An in-person meeting will be arranged with potential participants and the research coordinator to confirm study eligibility, to discuss the study procedure in greater detail, and to obtain informed written consent. At this meeting, potential participants will be provided with an information letter that outlines the study purpose, procedures and time commitment, followed by an in-person discussion with the study’s research coordinator. The research coordinator will explain: (1) the purpose of the study; (2) how the randomisation process works and (3) a general overview of the two treatments and outcome measures. The discussion will also include a thorough explanation of the potential risks and benefits associated with participation in the study. The research coordinator will ensure an understanding that they can withdraw from the study at any time without question or consequence and without any effect on the care that they or their families receive. Youth and their families will be given unlimited time to consider implications, ask questions and respond to the invitation to participate in the study.

Sample size
Fifty participants will be allocated to each treatment group for a total of 100 participants. This sample size was calculated using information from other concussion studies involving high school athletes, and children who experience persistent postconcussion symptoms.8 The α was set at 0.01 and power was set at 0.8. The difference between individuals receiving the active rehabilitation intervention versus the control group on the primary outcome measure, the PCSI, is expected to be six points with a pooled SD of 6.8.8 Calculations suggest a sample

<table>
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<tr>
<th>Table 1 Summary of study procedure</th>
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<tr>
<td><strong>Time</strong></td>
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<td>Initial visit (week 0)</td>
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<td>Week 1</td>
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size of 30 children per group. On the basis of previous clinical and research experience, an attrition rate of 25% is expected. As a result, this study will oversample with the aim of enrolling 50 participants per treatment group (100 participants in total).

**Randomisation**

Participants who meet all study inclusion criteria and consent to participate within the study will be randomly allocated to a treatment group using a stratified process. Owing to previous research indicating an increase in postconcussion symptoms reported by females, stratified randomisation will be used to ensure equal representation of gender across the intervention groups. A research coordinator who is not directly involved in this study will perform randomisation to ensure that the research study staff remain blinded to group allocation.

**Outcome measures**

All participants will be assessed at three time points throughout the duration of the study: week 0 (in-person session on enrolment in the study), week 2 (over the phone), and week 6 (in-person session on completion of the intervention). All outcome measures will be completed by a blinded assessor to minimise the risk for bias during data collection.

**Primary outcome**

The primary outcome of interest is postconcussion symptoms. This outcome was chosen because postconcussion symptoms are considered to be an essential clinical marker of recovery following concussion. Symptoms will be measured using a modified version of the PCSI. There are three available versions of the PCSI that will be used: (1) 21-item adolescent version, ages 13–18 years; (2) 18-item child version, ages 8–12 years and (3) 21-item parent-report scale. The PCSI captures the perceived presence and severity of symptoms following concussion. The modification is to add additional symptoms relating to sleep disturbance from the Post-Concussion Scale, the scale on which the PCSI was derived. Symptoms are rated on a Likert scale and are reported for before injury and after injury (current symptoms), to track changes in symptoms over brief intervals of time. PCSI has been validated for use with parents and youth following concussion. It has moderate to strong test–retest reliability (intraclass coefficients=0.65–0.89), moderate parent and youth concordance (r=0.44–0.65) and good convergent validity with a similar symptom checklist measure (r=0.8). It also has strong internal consistency. PCSI will be administered at baseline, week 2 and on completion of the intervention (week 6) for the experimental and control groups.

**Secondary outcomes**

Secondary measures include assessments of cognition, motor function, behaviour and emotions to evaluate functional recovery across a range of performance domains. Table 2 outlines the secondary measures used according to domain, along with the time frame within which each of the secondary measures will be administered within the study protocol.

**Interventions**

**Control intervention: standard care (comprehensive education)**

A standardised approach to delivering this concussion education and recommendations has been developed for the purposes of this study, and is reflective of the current standard care practices of the research team members representing three paediatric acute care and rehabilitation hospitals in Canada and the Ontario Neurotrauma Foundation’s Guidelines for diagnosing and managing pediatric concussions. The components of the standard care intervention include comprehensive education about the diagnosis of concussion, self-management strategies and return to activity and school guidelines. Specific curriculum topics are outlined in box 1.

Standard care will be provided to all participants regardless of group allocation. This education will be provided on an individual basis over the 6-week intervention period and consists of three 30 min in-person visits with an occupational therapist of the research team (see table 1).

**Experimental intervention: active rehabilitation intervention+ standard care**

In addition to the standard care (comprehensive education) described above, the experimental intervention involves an active rehabilitation programme that includes four components: (1) aerobic exercise; (2) coordination exercise; (3) visualisation exercise and (4) a home programme. This programme is based on a protocol developed and reported by Gagnon et al and has been adapted to be delivered over a period of 6 weeks. The 6-week intervention duration was determined on the basis of findings from Gagnon et al that symptom resolution occurred after an average of 4.4 weeks (SD=2.6 weeks) following the initiation of the active rehabilitation programme.

Once allocated to the experimental intervention (active rehabilitation), youth will complete a 1 h in-person session (week 0) that will consist of an introduction to the active rehabilitation protocol. Youths will begin by participating in an aerobic exercise of their choosing, either a fast-paced walk or light jog on a treadmill or stationary bicycle. Youths will wear a portable heart rate monitor and will be asked to exercise up to a predetermined submaximal heart rate that corresponds to 50–60% of their maximum heart rate (maximum heart rate=220 bpm—participant age) and/or a level 4 on the Pictorial Children’s Effort Rating Table (PCERT). Participants will continue the aerobic exercise until postconcussion symptoms are exacerbated or for a maximum of 15 min. The time to postconcussion symptom exacerbation (or 15 min) becomes the time...
interval for the aerobic exercise component of the participant’s rehabilitation programme (take home programme and in-person visits). This time interval can be adjusted (eg, made longer up to a maximum of 15 min) if the participant is able to demonstrate the ability to complete the time interval without an exacerbation of symptoms.

On completion of the aerobic training, youth will participate in light coordination exercises for up to 10 min. These activities will be tailored to the child’s favourite sport or physical activity. For example, a North American soccer player may be asked to complete a series of ball and footwork activities that are standard in typical practices. Heart rate will continue to be monitored to ensure that it does not exceed 50–60% of their maximal capacity. Since research has shown that youth experience decreased self-efficacy in relation to their physical activity performance after mTBI, these exercises combine light aerobic exercise with familiar sport activities in a monitored and supervised environment to target self-efficacy and physical function. Participants will be closely monitored for symptom exacerbation during the coordination exercises. If postconcussion symptoms are exacerbated, the exercises are stopped immediately and procedures for symptom exacerbation will be followed (see Safety reporting and monitoring section).

Following the completion of coordination exercise, youth will engage in a sport-specific visualisation exercise. The purpose of this exercise is to reassociate positive experiences in relation to physical activity participation and to target self-confidence in return to sports and physical activities. Participants will be asked to choose a specific physical activity associated with their favourite sport for the visualisation exercise. Specifically, they will be asked to choose an activity that they typically perform successfully and that is finite in duration (eg, footwork or dribbling drills in North American soccer).

**Box 1 Standard care**

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<tr>
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**Table 2 Secondary measures and time frame for their completion**

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<td></td>
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<td>Week 0: preintervention</td>
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<td>Postconcussion symptoms</td>
<td>Post-Concussion Symptom Inventory23</td>
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<td>Quality of life</td>
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<td></td>
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Compliance
Participants will be aware that they can withdraw from the study at any time without penalty. Those who choose to withdraw from the study, regardless of their treatment group assignment (standard care only vs active rehabilitation), will be given the opportunity to participate in the protocol’s final data collection point (week 6). This is to ensure that important data (such as ceased participation due to negative outcomes) are not excluded from the analysis. An analysis of participants who complete at least 80% of the intervention will also be included for exploratory purposes.

Participants will be asked to make up any missed evaluation sessions as soon as possible (preferably within 9 days of the date the evaluation was initially scheduled). Any missed active rehabilitation and standard education sessions are required to be made up as soon as possible. The 6-week intervention can extend to a maximum of 9 weeks secondary to missed sessions. The participant is considered to have dropped out of the study if these criteria are not met.

Co-intervention and contamination
On the basis of our experience, it is expected that some children will be pursuing concurrent physical rehabilitation interventions (eg, physiotherapy, massage therapy, chiropractic) for their postconcussion symptoms. Owing to the nature of the randomised control trial design and risk for co-intervention bias, youth will be asked not to participate in any concurrent physical rehabilitation for postconcussion symptoms throughout the duration of the study. Participation in a concurrent physical rehabilitation intervention would impede the study’s ability to determine the effectiveness of the active rehabilitation intervention as a treatment for postconcussion symptoms, and therefore is considered to be the exclusion criterion. After the in-person session will be held at week 6. During this session, youth will be verbally instructed in the standard return-to-activity protocol provided they report remaining symptom free at rest for at least 1 week. Youth who continue to experience persistent symptoms beyond the 6-week intervention may be referred to the Concussion Clinic at Holland Bloorview Kids Rehabilitation Hospital for evaluation by a physician and/or rehabilitation team.

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Co-intervention and contamination
On the basis of our experience, it is expected that some children will be pursuing concurrent physical rehabilitation interventions (eg, physiotherapy, massage therapy, chiropractic) for their postconcussion symptoms. Owing to the nature of the randomised control trial design and risk for co-intervention bias, youth will be asked not to participate in any concurrent physical rehabilitation for postconcussion symptoms throughout the duration of the study. Participation in a concurrent physical rehabilitation intervention would impede the study’s ability to determine the effectiveness of the active rehabilitation intervention as a treatment for postconcussion symptoms, and therefore is considered to be the exclusion criterion. After the in-person session will be held at week 6. During this session, youth will be verbally instructed in the standard return-to-activity protocol provided they report remaining symptom free at rest for at least 1 week. Youth who continue to experience persistent symptoms beyond the 6-week intervention may be referred to the Concussion Clinic at Holland Bloorview Kids Rehabilitation Hospital for evaluation by a physician and/or rehabilitation team.

Compliance
Participants will be aware that they can withdraw from the study at any time without penalty. Those who choose to withdraw from the study, regardless of their treatment group assignment (standard care only vs active rehabilitation), will be given the opportunity to participate in the protocol’s final data collection point (week 6). This is to ensure that important data (such as ceased participation due to negative outcomes) are not excluded from the analysis. An analysis of participants who complete at least 80% of the intervention will also be included for exploratory purposes.

Participants will be asked to make up any missed evaluation sessions as soon as possible (preferably within 9 days of the date the evaluation was initially scheduled). Any missed active rehabilitation and standard education sessions are required to be made up as soon as possible. The 6-week intervention can extend to a maximum of 9 weeks secondary to missed sessions. The participant is considered to have dropped out of the study if these criteria are not met.
CONCLUSION: IMPACT ON CLINICAL PRACTICE

This article describes a protocol for a randomised control trial that tests the efficacy of two interventions for the rehabilitation of youth with persistent post-concussion symptoms: active rehabilitation plus standard care (comprehensive education) and standard care only. Results from primary and secondary measures will improve our understanding of the efficacy of the two interventions in relation to physical, cognitive, socioemotional and functional recovery. Knowledge from this study will help clinicians make informed evidence-based decisions regarding return to activity following concussion.

CURRENT STUDY STATUS

This trial is set to begin recruitment in July/August 2015.

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Contributors IJG designed the experimental intervention. NR, IJG, GLI, CD and PF refined the study protocol and study implementation. DG coordinated the protocol manuscript development. All the authors contributed to the writing and editing of the manuscript.

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Competing interests GLI has been reimbursed by the government, professional scientific bodies and commercial organisations for discussing or presenting research relating to mild TBI and sport-related concussion at meetings, scientific conferences and symposia. He has a clinical and consulting practice in forensic neuropsychology involving individuals who have sustained mild TBIs. He has received research funding from several test publishing companies, including ImPACT Applications, Inc, CNS Vital Signs and Psychological Assessment Resources (PAR, Inc). He is a co-investigator, collaborator or consultant on grants relating to mild TBI funded by several organisations, including, but not limited to, the Canadian Institute of Health Research, Alcohol Beverage Medical Research Council, Rehabilitation Research and Development (RR&D) Service of the US Department of Veterans Affairs, Vancouver Coastal Health Research Institute and Roche Diagnostics Canada. PF is the founder and co-owner of Cortex Medicine and rehabilitation clinic.

Ethics approval Ethics approval has been received from Bloorview Research Institute and Holland Bloorview Kids Rehabilitation Hospital’s Research Ethics Board.

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