Existing data indicates that more than 1.5 million people (other data indicate that number is low) experience a traumatic brain injury (TBI) each year in the United States. The Kentucky Traumatic Brain Injury Prevalence study published in 2004 revealed that almost one-fifth of Kentucky households [in the study] reported having at least one member with a history of head injury, almost two-thirds of those injured were male, motor vehicle accidents were the leading cause of the reported injuries and over 60% of the injuries reported occurred prior to age 21 years of age. Obviously, traumatic brain injury, often referred to as The Silent Epidemic, is a major problem in Kentucky as it is nationwide.

Historically, clinicians and investigators have classified traumatic brain injury as mild, moderate and severe by using scores of the Glasgow Coma Scale, a widely-used scoring system to assess coma and impaired consciousness (Teasdale and Jennett 1974; Rimel, Giordani, Barth, et al. 1981, 1982). Usually, moderate and severe head injuries are diagnosed in a timely manner. However, mild traumatic brain injuries (MTBI) and evolving brain injuries, such as subdural hematomas and chronic traumatic encephalopathy, oftentimes are missed.

According to the September 2003 Center for Disease Control Report to Congress on Mild Traumatic Brain Injury in the United States, the conceptual definition of MTBI is an injury to the head as a result of blunt trauma or acceleration or deceleration forces that result in one or more of the following conditions:

Any period of observed or self-reported:
- Transient confusion, disorientation, or impaired consciousness;
- Dysfunction of memory around the time of injury;
- Loss of consciousness lasting less than 30 minutes.
- Observed signs of neurological or neuropsychological dysfunction, such as:
- Seizures acutely following injury to the head;
- Among infants and very young children: irritability, lethargy or vomiting following head injury;
- Symptoms among older children and adults such as headaches, dizziness, irritability, fatigue or poor concentration, when identified soon after injury, can be used to support the diagnosis of mild TBI but generally cannot be used to make the diagnosis absent of loss of consciousness or altered consciousness.

It should be emphasized that loss of consciousness and/or impact to the head with another object are not necessary for a head injury to occur and are not required criteria for diagnostic purposes.

It has often been said that the only cure for a brain injury is prevention. Employees of many businesses are at risk due to the dangerous nature of the specific business. Helmets, safety equipment and extensive preventative education will hopefully eliminate or reduce the number of work related head injuries. If an employee is injured on the job, the employer needs to have a process in place whereby a thorough history of the event resulting in the injury, and the injured person’s medical condition, are promptly evaluated.

Businesses should establish protocols and policies geared toward eliminating injuries to their patrons. Thorough documentation should be maintained by the business in the event a patron is injured. Of course, prompt medical care should be available and having personnel available trained in CPR, blood loss control management and brain injury assessment and management is recommended.

Within the past few years much has been written about sports related head injuries, both involving professional athletes and college and high school age athletes. The diagnosis of Chronic Traumatic Encephalopathy (CTE) and the recognition of brain injuries in the National Football League, along with a class action lawsuit, has only recently gained national attention with high-profiled cases involving athletes such as Mike Webster and Chris Henry.

Kentucky has taken action to protect its school age athletes. In 2012, Governor Beshear signed into law HB 281 protecting student athletes from the dangers of sports concussion, especially from Second Impact Syndrome, a sometimes fatal event that occurs when an athlete receives a second concussion prior to recovering from the first concussion. Previously, on May 27, 2010, Governor Beshear signed into law HB 285, known as the Shaken Baby Syndrome prevention law.

The Brain Injury of Alliance of Kentucky (BIAK) has been instrumental in TBI advocacy. BIAK is based in Louisville but recently started an outreach program to extend education, advocacy and support throughout the Commonwealth by establishing a Board of Directors in the Northern Kentucky, Lexington and Lebanon areas. The Kentucky Legislature has also provided funding to BIAK establishing a program for veterans to assure they are aware of TBI resources when returning from war and thereafter.

The increase in TBI awareness has resulted in brain injury support groups springing up in many parts of the Commonwealth interacting with BIAK and the TBI Trust Fund, as well as local and state legislators. It is important for TBI survivors and their families to realize they are not alone and there is support for them assur-
ing they have a chance for good employment and educational opportunities.

Without doubt, during the past few years in Kentucky, the victims of The Silent Epidemic, and our society, including businesses and schools, have gradually come to realize that we can no longer be silent about traumatic brain injuries. We must take action to reduce the number of brain injuries and assure that those injured, and their families, receive proper treatment and care, have resources available to deal with all phases of recovery, are made aware of resources available and have opportunities to work, attend school and enjoy life to the fullest extent possible.

Next time I will discuss how legal cases involving TBIs are different from other personal injury cases. For more information about traumatic brain injury contact the Brain Injury Alliance of Kentucky at (502) 493-0609.