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ODG Evidence-Based Support: Head section

I have been asked to review the Head section of the ODG and respond to the questions: do the Guidelines 1) improve medical treatment for injured workers, 2) make treatment and claims processing more efficient and cost effective, and 3) the guidelines adequately cover the body parts or conditions.

In general the Head section satisfies all of these conditions however I do have some observations.

First, the Head section is subtitled:
(trauma, headaches, etc., not including stress and mental disorders) however the primary references in the section to headaches are to post-traumatic headaches. I see no section devoted specifically to migraine nor do I find such a heading under the Pain section.

Regarding migraine: the specific procedures/treatments listed for headaches include use of triptans that are given at the time of a headache. There are headings for "botulinum toxin for chronic migraine", greater occipital nerve blocks for primary headache, and acupuncture. Under the heading of "Migraine pharmaceutical treatment" these same treatments are mentioned but there is no reference to the drugs commonly used for migraine prophylaxis such as topiramate, Depakote, propranolol and some antidepressants. These can be quite effective and should be considered, especially before botulinum toxin.

There are less common conditions such as post traumatic facia/trigeminal neuralgias which are not mentioned.

Thus the majority of the Head section is directed at traumatic brain injury and minimal attention is given to headache disorders. Perhaps that is because headaches are uncommon consequences of industrial injury.

The bulk of the Head section deals with concussion/mild traumatic brain injury and its sequellae. Anticonvulsant therapy for post traumatic epilepsy is discussed.

There are some controversial opinions such as the occurrence of anxiety, depression and PTSD after TBI. While these conditions certainly may result from TBI there is not a clear statement that some individuals with primary anxiety, depression or PTSD may be mistaken as having symptoms attributed to a concussion when no TBI occurred. The military has made this distinction recognizing that some soldiers

initially considered to have TBI were subsequently found to have pure PTSD instead, resulting in the same symptoms.

The ODG does note that the symptoms of a concussion are not specific and many in the normal population exhibit the same symptoms without having experienced a TBI. This is a significant issue because the application of the ODG protocols is dependent on having an accurate diagnosis. When an incorrect diagnosis is applied to the guidelines unnecessary or inappropriate treatment will result. Since the conditions being treated in this section are largely without a definitive diagnostic test and the associated symptoms are subjective accurate diagnosis may be difficult.

That being said the ODG procedural recommendations are reasonable as listed.

As a neurologist with a background in neuro-ophthalmology I take some exception to the sections addressing vision evaluation and vision therapy. Clearly TBI with or without orbital trauma can cause a variety of visual and oculomotor deficits. The recommendation that some patients may need to see a "neurodevelopmental optometrist" should include the option of seeing a neuro-ophthalmologist (who may be primarily an ophthalmologist or a neurologist by training and likely is far better trained to evaluate these conditions). In my experience there are some neuro-optometrists who make a diagnosis of convergence insufficiency in every patient they see, including some who are shown to never have experienced a TBI. This is another example of the problem of applying the ODG protocols when the diagnosis is incorrect.

Finally I observe that the vast majority of patients with a mild TBI and lingering symptoms of headache, dizziness, irritability, impaired concentration and disrupted sleep are most commonly managed by low doses of medications including an anticonvulsant such as topiramate and/or an antidepressant such as a tricyclic. These agents are in the general categories listed in the Medications section but no specific reference is given to the symptoms that those medications might be used to manage.

In sum, I believe the Official Disability Guidelines do meet the criteria to:
1) improve medical treatment for injured workers, 2) make treatment and claims processing more efficient and cost effective, and 3) the guidelines adequately cover the body parts or conditions and I recommend the Head section for implementation by the Commission.

Respectfully,

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