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Health care utilization and outcomes in older adults after Traumatic Brain Injury: A CENTER-TBI study

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ABSTRACT

Introduction: The incidence of Traumatic Brain Injury (TBI) is increasingly common in older adults aged ≥65 years, forming a growing public health problem. However, older adults are underrepresented in TBI research. Therefore, we aimed to provide an overview of health-care utilization, and of six-month outcomes after TBI and their determinants in older adults who sustained a TBI.

Methods: We used data from the prospective multi-center Collaborative European NeuroTrauma Effectiveness Research in Traumatic Brain Injury (CENTER-TBI) study. In-hospital and post-hospital health care utilization and outcomes were described for patients aged ≥65 years. Ordinal and linear regression analyses were performed to identify determinants of the Glasgow Outcome Scale Extended (GOSE), health-related quality of life (HRQoL), and mental health symptoms six-months post-injury.

Results: Of 1254 older patients, 45% were admitted to an ICU with a mean length of stay of 9 days. Nearly 30% of the patients received inpatient rehabilitation. In total, 554/1254 older patients completed the six-month follow-up questionnaires. The mortality rate was 9% after mild and 60% after moderate/severe TBI, and full recovery based on GOSE was reported for 44% of patients after mild and 6% after moderate/severe TBI. Higher age and increased injury severity were primarily associated with functional impairment, while pre-injury systemic disease, psychiatric conditions and lower educational level were associated with functional impairment, lower generic and disease-specific HRQoL and mental health symptoms.

Conclusion: The rate of impairment and disability following TBI in older adults is substantial, and poorer outcomes across domains are associated with worse preinjury health. Nonetheless, a considerable number of patients fully or partially returns to their preinjury functioning. There should not be pessimism about outcomes in older adults who survive.

Introduction

Traumatic Brain Injury (TBI) is a growing public health problem and a major cause of death and disability worldwide [1]. TBI can cause long-term impairment in physical, cognitive and emotional functioning [2–4]. In recent decades, there is a shift in the TBI population towards older age groups (≥65 years), especially in high-income countries where falls represent the primary cause of TBI [5]. This can be explained by a combination of improved traffic safety regulations, resulting in a decrease in road traffic injuries, and increased life expectancy with greater mobility in older people [5].

Compared to younger TBI patients, older patients have longer hospital stays [6,7], a slower recovery [8–10] and are more likely to die due to their TBI. [11] Recovery after TBI in older adults may be hampered by the presence of comorbidity, the presence of physical and mental health problems prior to injury, and the use of medication, which could complicate the treatment of TBI. Prior studies suggest that measures of pre-injury functioning and frailty are

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stronger predictors of outcome than age [12]. Nevertheless, previous TBI studies have often excluded older adults, especially those with pre-existing psychiatric and neurological problems [13]. While results from younger adult studies suggest a strong relationship between pre-injury characteristics and outcome after TBI, evidence from older adult cohorts is needed [14]. Chronic health complaints are also associated with increased healthcare utilization and costs [15]. In the general injury population, older patients have a higher health care utilization after discharge [16,17]. A prior study found that older patients (75-84 years) had significantly higher rates of rehospitalisation, home visits and informal care, and significantly lower rates of out-patient rehabilitation care compared to younger patients (55-74 years) [18].

Research on both health-related quality of life (HRQoL) and psychological outcomes in older adults after TBI is scarce. Previous HRQoL studies included small sample sizes and few studies included both generic and disease-specific measures of HRQoL [19]. In some studies, individuals showed a higher risk for emergence of psychiatric disorders including depression, anxiety and post-traumatic stress disorder (PTSD) after TBI [20], whereas in other studies older adults reported less psychological distress and less symptoms of depression and anxiety than younger adults [14]. Nonetheless, a systematic review on psychiatric assessments after TBI, concluded that psychological outcomes were insufficiently addressed in the emerging group of older TBI patients [20].

Since the number of older adults with TBI is substantial and has been increasing, it is important to investigate characteristics and outcomes in the older TBI population [21]. A recent systematic review on outcomes following mild TBI in older adults suggested “cautious optimism” in terms of long-term functional recovery and psychological health [14]. Better understanding of health care utilization and health outcomes of older people after TBI might help clinicians to set treatment goals. Furthermore, insight into patient characteristics related to poor outcomes in older patients may support the development of prognostic models for the older TBI population. Therefore, the aims of this study were to: 1) describe health care utilization following TBI in older adults, 2) assess six-month functional outcome, generic and disease-specific HRQoL, PTSD, anxiety and depression symptoms following TBI in older adults, and 3) identify determinants of six-month outcomes in the older TBI population.

Methods

Study design and population

We analyzed data from the prospective multi-center longitudinal observational Collaborative European NeuroTrauma Effectiveness Research in Traumatic Brain Injury (CENTER-TBI) core study (version 3.0; registered at clinicaltrials.gov NCT02210221) [22]. Patients from 63 centers were invited to participate in the study from December 2014 to December 2017. Data was collected for patients with a clinical diagnosis of TBI, an indication for computed tomography (CT), who presented to a hospital within 24 hours after injury. Patients with a severe pre-existing neurological disorder, which could confound outcome assessments, were excluded. In CENTER-TBI core study, data from 4509 participants were available for analysis. For an overview of baseline characteristics, all adult (≥16 years) patients were included in this study. In all further analyses, only patients aged ≥65 years were included: 1254 patients recruited from 59 participating centres .

Informed consent was obtained according to local regulations and the Medical Ethics Committees approved the CENTER-TBI study in all participating centers (https://www.centertbi.eu/project/ethical-approval).

Measures

Demographics, pre-injury characteristics

Sociodemographic characteristics (including sex, age, living situation, education level), medical history and clinical and injury characteristics were assessed at the time of enrolment in the study. Age was categorized into three groups: 65 to 74 years, 75 to 84 years, and 85 years or older for descriptive analyses, and used as a continuous variable in regression analyses.

Living situation was categorized as living alone or not. Level of education was divided into primary school, secondary school, post-high school training and college/university. Pre-injury health status was assessed with the American Society of Anaesthesiologists - physical status classification system (ASA-PS) and categorized as healthy, mild systemic disease and severe systemic disease/threat to life. Medication use included anticoagulants/platelets aggregation inhibitor use and beta-blocker use. Pre-injury psychiatric conditions included depression, anxiety, sleep disorder, schizophrenia, substance abuse disorder and other.

Early computed tomography (CT) assessed the presence of intracranial traumatic abnormalities. TBI severity was rated using the Glasgow Coma Scale (GCS) [23]. TBI was considered mild in patients with GCS 13-15, moderate in patients with GCS 9-12, and severe in patients with GCS of 3-8. The injury severity score (ISS), which ranges from 0-75, indicates overall injury severity. It is calculated as the sum of square of the three highest values of the Abbreviated Injury Scale Score (AIS) from different body regions [24]. Injury mechanism was categorized as falls, road traffic incident, and other.

Health care utilization

Data on hospital admission, ICU admission, and inpatient and outpatient rehabilitation were collected. Length of stay at the ward and ICU were collected using several sources of CENTER-TBI forms. For rehabilitation, the transitions of care forms were consulted. In addition to collecting information on post-injury pathways of care from providers, information on inpatient and outpatient rehabilitation were reported by a patient or proxy in questionnaires assessed at six-month follow-up. Inpatient rehabilitation included admission to a general, geriatric, psychiatric or specialized TBI rehabilitation unit, or nursing home unit. Outpatient rehabilitation included physical therapy, occupational therapy, speech therapy, therapeutic recreation, cognitive remediation, vocational services, psychological services, nursing services, comprehensive day treatment, peer mentoring, social work, independent living, and home health.

Functional outcome at six months

Functional outcome was assessed at 6 months with the Glasgow Outcome Scale Extended (GOSE). When performed outside the time window (5-8 months), it was imputed based on GOSE measurements at other time points using a multi-state model [25]. The GOSE has eight ordinal categories–Dead (1); vegetative state (2); lower severe disability (3); upper severe disability (4); lower moderate disability (5); upper moderate disability (6); lower good recovery (7); and upper good recovery (8). In this study, the categories ‘vegetative state’ and ‘lower severe disability’ were combined, as these could not be differentiated for GOSE ratings based on postal questionnaires because patients in a vegetative state require specialized tests for responsiveness, and this cannot be assessed by a questionnaire [26].

We gave centres flexibility in outcome assessment to help maximize follow-up rates and to tailor approaches to patients. The GOSE was assessed by a postal questionnaire or a structured interview by a trained assessor (telephone or face to face). Answers to GOSE questionnaires could be given by patients alone, and if that was not possible by patients with the help of a relative/ caregiver,

or by a relative/caregiver alone. The ratings from interviews and questionnaires showed good agreement [27]. Interviews and questionnaires were scored centrally, and when both had been carried out, the rating was based on the interview.

Generic and disease-specific HRQoL at six months

Generic HRQoL was assessed using the 12-item short form health survey (SF-12v2) [28]. The HRQoL is summarized as a mental (MCS) and a physical component score (PCS). If there was no available SF-12v2 score, the score was derived using SF-36v2 if available [25]. The raw PCS-12 and MCS-12 scores were transposed as norm-based t-scores with a mean of 50 and a standard deviation of 10. Scores <40 were classified as impaired HRQoL [29].

The six-item Quality of Life after Brain Injury Overall Scale (QOLIBRI-OS) is a disease specific instrument and provides a profile of HRQoL in domains affected by TBI [30]. The instrument assesses the overall satisfaction with different domains of life. The total score scale ranges from 0-100 and scores <52 were classified as impaired HRQoL [31].

The measures of HRQoL were completed by patients alone, and for a small subset of patients by a relative/caregiver/friend [32].

Psychological symptoms at six months

Post-traumatic stress. PTSD symptoms were assessed with the PCL-5 [33]. The PCL-5 includes 20 items reflecting the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) diagnostic criteria of PTSD. Items are scored on a five-point Likert scale ranging from 0 (not at all) to 4 (extremely) and the sum of scores ranges from 0 to 80. A total score ≥33 was considered clinically relevant [34].

Depression. Depression symptoms were assessed with The Patient Health Questionnaire (PHQ-9) [35]. It contains nine items, which are scored on a four-point Likert scale ranging from 0 (not at all) to 3 (nearly every day). The sum score ranges from 0-27. A score of 5-9 indicated mild depressive symptoms and a score of ≥10 indicate moderate to severe depressive symptoms.

Anxiety. Anxiety symptoms were assessed with the Generalized Anxiety Disorder questionnaire (GAD-7) [36], a seven-item instrument with a four-point Likert scale ranging from 0 (not at all) to 3 (nearly every day). The sum score ranges from 0-21 with a score from 5 to 9 indicating mild and a score of ≥10 indicating moderate to severe anxiety symptoms.

The measures of psychological symptoms were completed by patients alone.

All questionnaires that were not available in local languages of participating centres were translated and linguistically validated [37]. The questionnaires were scored centrally.

Statistical analysis

Descriptive statistics for baseline characteristics, health care utilization, and health outcomes were presented with percentages for categorical variables and median and inter quartile range (IQR) for continuous variables. Differences in baseline characteristics were compared between three types of responders–Those that completed at least one questionnaire (SF-12v2, QOLIBRI-OS, PCL-5, PHQ-9, GAD-7) at six months post-injury; non-responders; and those who died within six months post TBI, making use of chi-square and Mann-Whitney U tests. Health care utilization was reported for all patients with available data. Health outcomes were reported separately by age group (65–74, 75–84 and ≥85 years of age). Differences by age group were tested using the Kruskal-Wallis test. The association of possible determinants with multiple outcomes following TBI was analyzed with univariable and multivariable ordinal and linear regression analyses, and quantified with odds ratios (ordinal regression) and regression coefficients (linear regression

For the regression analyses, missing baseline characteristics were imputed using Multivariate Imputation by Chained Equation (MICE) approach based on an imputation model including all baseline characteristics, auxiliary variables (years of education) and all six-month outcomes, using the *mice* package in R [38]. For ordinal logistic regression, the model performance was assessed with the area under the receiver operating curve, which corresponds to the c statistic. The c statistic was used to quantify the ability of the model to discriminate between patients with different outcome levels . The c statistic ranges between 0.50 (no discrimination) and 1.0 (perfect discrimination). For linear regression, model performance was quantified with the adjusted coefficient of determination (R^2).

Analyses were performed in SPSS V.25 (statistical package for social sciences, Chicago, Illinois, USA) and R (version 4.0.4) (R foundational for statistical computing, Vienna, Austria) [39].

Results

Baseline characteristics

The study included 1254 older adults (59% male) with a median age of 74 (IQR: 69-80) (**Table 1**). There were 355 (28%) patients categorized as having moderate/severe TBI, and the median ISS was 16 (IQR: 9-25). Most patients had pre-injury systemic disease (77%) and 13% had a pre-injury psychiatric condition. Falls were the primary cause of TBI (67%). In total, 554 of 1254 (44%) patients completed at least one survey on outcome after injury at six-month (**Table 1**). The median ISS was twice as high for deceased patients (26, IQR 20-43) compared to responders (13, IQR 8-21) and non-responders (13, IQR 8-25). Of responders, 14% were classified as moderate/severe TBI patients, while 69% of deceased patients were classified as moderate/severe TBI patients.

Compared to younger adult (16-64) patients, older patients were more often female, more often lived alone, reported more pre-injury psychical and psychiatric conditions and more often used anticoagulant, platelet aggregation inhibitors and beta-blockers (Table 1). The mortality at discharge was 19% in the older age group, compared to 6% in the younger population.

Health care utilization of older patients after TBI

Of 1254 patients, 84% (1046) were admitted to a hospital ward and/or ICU (**Table 2**). There were 566 (45%) patients admitted to an ICU with mean LOS of 9.0 (SD=10.5) days. Discharge to an in-patient rehabilitation unit occurred in 22% of patients after mild TBI and in 61% of patients after moderate/severe TBI. About half of patients age 65-74 years (49%) and age 75-84 years (48%) were admitted to an ICU with a mean of respectively 10 (SD=11) and 8 (SD=10) days and 20% of persons aged ≥85 years were admitted to an ICU with a mean of 6 days (SD=6). Of males, 51% were admitted to an ICU with the LOS of 10 days (SD=11) and of females, 37% with a LOS of 8 days (SD=9). Of patients who survived discharge (n=1056), 30% of older adults received in-patient rehabilitation care and 12% received out-patient rehabilitation care. Of patients after mild TBI, 22% and of patients after moderate/severe TBI, 61% received in-patient rehabilitation care in the first six months after injury

Table 1
Characteristics of the older adult TBI population in the CENTER-TBI study by response status at six months[a,b].

Variable	Total population	Responders*	Non-responders	Deceased	Responders vs. Non-responders	Responders vs. deceased
N	N=1254	N=554	N=423	N=277	p-value	p-value
Age, median (IQR)	74 (69-80)	73 (68-78)	75 (69-81)	76 (71-82)	<0.001	<0.001
65-74 years	634 (50.6%)	318 (57.4%)	209 (49.4%)	107 (38.6%)		
75-84 years	479 (38.2%)	193 (34.8%)	158 (37.4%)	128 (46.2%)		
≥85 years	141 (11.2%)	43 (7.8%)	56 (13.2%)	42 (15.2%)		
Sex, male, n (%)	741 (59.1%)	320 (57.8%)	234 (55.3%)	187 (67.5%)	0.445	0.007
Living alone, n (%)	364 (29.0%)	157 (28.3%)	150 (35.5%)	57 (20.6%)	0.016	0.016
Missing, n (%)	4 (0.3%)	1 (0.2%)	2 (0.5%)	1 (0.4%)		
Highest educational level					<0.001	0.006
Primary school	254 (20.3%)	120 (21.7%)	96 (22.7%)	38 (13.7%)		
Secondary school	272 (21.7%)	128 (23.1%)	105 (24.8%)	39 (14.1%)		
Post-high school training	172 (13.7%)	96 (17.3%)	60 (14.2%)	16 (5.8%)		
College/university	173 (13.8%)	118 (21.3%)	41 (9.7%)	14 (5.1%)		
Missing, n (%)	383 (30.5%)	92 (16.6%)	121 (28.6%)	170 (61.4%)		
Pre-injury ASA-PS class, n (%)					0.034	<0.001
Healthy	256 (20.4%)	142 (25.6%)	78 (18.4%)	36 (13.0%)		
Mild systemic disease	659 (52.6%)	287 (51.8%)	234 (55.3%)	138 (49.8%)		
Severe systemic disease/threat to life	300 (23.9%)	118 (21.3%)	101 (23.9%)	81 (29.2%)		
Missing, n (%)	39 (3.1%)	7 (1.3%)	10 (2.4%)	22 (7.9%)		
Pre-injury physical conditions, n (%)					0.245	0.276
None	133 (10.6%)	66 (11.9%)	44 (10.4%)	23 (8.3%)		
1	275 (21.9%)	130 (23.5%)	91 (21.5%)	54 (19.5%)		
2	296 (23.6%)	140 (25.3%)	92 (21.7%)	64 (23.1%)		
3	236 (18.8%)	99 (17.9%)	78 (18.4%)	59 (21.3%)		
4 or more	299 (23.8%)	119 (21.5%)	115 (27.2%)	65 (23.5%)		
Missing, n (%)	15 (1.2%)	0 (0%)	3 (0.7%)	12 (4.3%)		
Pre-injury psychiatric condition, n (%)	164 (13.1%)	60 (10.8%)	63 (14.9%)	41 (14.8%)	0.034	0.034
Missing, n (%)	47 (3.7%)	4 (0.7%)	18 (4.3%)	25 (9.0%)		
Prior TBI, n (%)	107 (8.5%)	50 (9.0%)	40 (9.5%)	17 (6.1%)	0.694	0.444
Missing, n (%)	122 (9.7%)	29 (5.2%)	35 (8.3%)	58 (20.9%)		
Intracranial traumatic abnormality, n (%)	647 (51.6%)	287 (51.8%)	185 (43.7%)	175 (63.2%)	0.110	<0.001
Missing, n (%)	196 (15.6%)	56 (10.1%)	68 (16.1%)	72 (26.0%)		
Anticoagulants and platelets aggregation inhibitor use, n (%)					0.741	<0.001
Anticoagulant	225 (17.9%)	87 (15.7%)	77 (18.2%)	61 (22.0%)		
Platelet aggregation inhibitor	325 (25.9%)	148 (26.7%)	96 (22.7%)	81 (29.2%)		
Both	25 (2.0%)	8 (1.4%)	8 (1.9%)	9 (3.2%)		
No	618 (49.3%)	303 (54.7%)	216 (51.1%)	99 (35.7%)		
Missing, n (%)		8 (1.4%)	26 (6.1%)	27 (9.7%)		
Beta blocker use, n (%)	314 (25.0%)	131 (23.6%)	105 (24.8%)	78 (28.2%)	0.362	<0.001
Missing, n (%)	93 (7.4%)	16 (2.9%)	34 (8.0%)	43 (15.5%)		
Care pathway, n (%)					0.015	<0.001
ER	209 (16.7%)	127 (22.9%)	76 (18.0%)	6 (2.2%)		
Hospital ward	493 (39.3%)	254 (45.8%)	176 (42.3%)	60 (21.7%)		
ICU	552 (44.0%)	173 (31.2%)	168 (39.7%)	211 (76.2%)		
TBI Severity, n (%)					0.005	<0.001
Mild (GCS 13-15)	862 (68.7%)	468 (84.5%)	326 (78.9%)	68 (24.5%)		
Moderate/Severe (GCS 3-12)	355 (28.3%)	77 (13.9%)	87 (21.1%)	191 (69.0%)		
Missing, n (%)	37 (3.0%)	9 (1.6%)	10 (2.4%)	18 (6.5%)		
Injury mechanism					0.080	0.729
Falls	837 (66.7%)	358 (64.6%)	302 (71.4%)	177 (63.9%)		
Road traffic accident	284 (22.6%)	136 (24.5%)	83 (19.6%)	65 (23.5%)		
Other	133 (10.6%)	60 (10.8%)	38 (9.0%)	38 (9.0%)		
ISS, median (IQR)	16 (9-25)	13 (8-21)	13 (8-25)	26 (20-43)	0.079	<0.001

IQR–Inter quartile range, ASA-PS class: American Society of Anesthesiologists Physical Status classification, TBI: Traumatic Brain Injury, GCS = Glasgow Coma Scale, ISS= Injury Severity Score, MVA: motor vehicle accident.
*patients who completed at least one questionnaire (SF-12v2, QOLIBRI-OS, PCL-5, PHQ-9, GAD-7) at six months post-injury.
[a] response vs non-response.
[b] response vs deceased.

Outcomes of older patients after TBI

Of 722 patients with mild TBI, 9% died within six months compared to 60% of 320 patients with moderate/severe TBI (Table 3). Around 30% of patients with mild and 83% of patients with moderate/severe TBI had a poor functional outcome (GOSE ≤ 4). Of patients with mild or moderate/severe TBI, respectively 41% and 42% had impaired physical HRQoL scores and 22% and 21% had impaired mental HRQoL scores. Elevated symptoms of PTSD, depression and anxiety were present in respectively 5%, 15% and 9% of patients with mild TBI and 6%, 11% and 9% of patients after moderate/severe TBI.

Of patients aged 65-74 years, 75-85, and ≥85 years, respectively 19%, 31% and 37% died within six months post-injury. For all outcomes, the differences in outcome between 65-74 years and ≥85 years were statistically significant, with lower GOSE and HRQoL

Table 2
Hospital admission and in- and out-patient rehabilitation services for older adults in CENTER-TBI study.

	Ward		ICU		six-month in-patient rehabilitation[a]	six-month out-patient rehabilitation[a]
	Patients admitted to a ward, N (%)[b]	Mean number of days (SD)*	Patients admitted to an ICU, N (%)[c]	Mean number of days (SD)*	N (%)[d]	N (%)[e]
Total	817 (65.4)	9.6 (15.0)	566 (45.3)	9.0 (10.5)	285 (29.3)	117 (12.2)
Age						
65-74 years	408 (64.7)	9.3 (11.4)	306 (48.5)	10.0 (10.9)	139 (26.4)	73 (14.0)
75-84 years	322 (67.2)	10.4 (19.0)	231 (48.2)	8.2 (10.1)	124 (35.3)	42 (12.1)
≥85 years	87 (62.6)	8.0 (12.0)	29 (20.9)	5.7 (6.1)	22 (23.2)	2 (2.2)
Sex						
Male	490 (66.4)	10.2 (13.9)	375 (50.8)	9.8 (10.9)	165 (29.4)	61 (10.9)
Female	327 (64.0)	8.6 (16.4)	191 (37.4)	7.5 (9.4)	120 (29.3)	56 (14.0)
Injury mechanism						
Fall	547 (65.6)	8.6 (15.1)	319 (38.2)	8.2 (10.0)	174 (26.4)	70 (10.8)
Road traffic incident	199 (70.3)	10.8 (11.7)	171 (60.4)	9.4 (10.5)	84 (38.9)	39 (18.1)
Other	71 (53.8)	13.4 (20.5)	76 (57.6)	11.5 (11.9)	27 (27.6)	8 (8.2)
Pre-injury ASA-PS class, n (%)						
Healthy	182 (71.7)	8.0 (10.6)	114 (44.9)	10.0 (11.8)	51 (23.4)	38 (17.5)
Mild systemic disease	429 (65.1)	9.6 (13.0)	292 (44.3)	8.8 (10.3)	155 (29.8)	57 (11.1)
Severe systemic disease/threat to life	192 (64.6)	10.5 (21.0)	127 (42.8)	8.8 (10.0)	70 (32.3)	22 (10.4)
TBI Severity, n (%)						
Mild (GCS 13-15)	858 (70.2)	8.3 (15.0)	222 (25.9)	7.6 (10.2)	170 (22.0)	86 (11.3)
Moderate/Severe (GCS 3-12)	197 (55.6)	13.4 (14.4)	318 (89.8)	9.9 (10.4)	112 (60.9)	29 (15.8)

*Length of hospital stay for those patients admitted to a ward/ICU.
[a] Based on patients who survived discharge (n=1056).
[b] 5 (0.4%) missing values.
[c] 5 (0.4%) missing values.
[d] 84 (8.0%) missing values.
[e] 97 (9.2%) missing values.

Table 3
Distribution of outcome variables for the total population of older adults after TBI and by TBI severity.

	Total	TBI severity* Mild	Moderate/ Severe	p-value
Functional outcome at 6 months				
GOSE	**n=1073/1254**	***n=722/862***	***n=320/355***	<0.001
1 (dead)	277 (25.8%)	68 (9.4%)	191 (59.7%)	
3 (vegetative state/lower severe disability)	120 (11.2%)	65 (9.0%)	54 (16.9%)	
4 (upper severe disability)	56 (5.2%)	43 (6.0%)	12 (3.8%)	
5 (lower moderate disability)	47 (4.4%)	37 (5.1%)	10 (2.8%)	
6 (upper moderate disability)	57 (5.3%)	48 (5.6%)	9 (2.8%)	
7 (lower good recovery)	175 (16.3%)	147 (20.4%)	26 (8.1%)	
8 (upper good recovery)	341 (27.2%)	314 (43.5%)	18 (5.6%)	
HRQoL at 6 months				
SF-12v2 PCS	***(n=541/1254)***	***n=461/862***	***n=71/355***	
Impaired SF-12v2 physical score (<40)	218 (40.3%)	187 (40.6%)	30 (42.3%)	0.787
Median (IQR)	43.3 (34.1-50.5)	43.3 (34.6-50.8)	42.3 (31.8-49.8)	0.315
SF-12v2 MCS	***(n=541/1254)***	***n=461/862***	***n=71/355***	
Impaired SF-12v2 mental score (<40)	117 (21.6%)	102 (22.1%)	15 (21.1%)	0.850
Median (IQR)	50.8 (42.1-58.3)	51.2 (42.0-58.3)	49.3 (41.8-58.2)	0.680
QOLIBRI-OS	***(n=544/1254)***	***n=460/862***	***n=75/355***	
Impaired QOLIBRI-OS (<52)	121 (22.2%)	102 (22.2%)	18 (24.0%)	0.725
Median (IQR)	71.0 (54.0-79.0)	71.0 (54.0-82.0)	67 (54.0-79.0)	0.253
Mental health symptoms at 6 months				
PTSD, PCL-5	***(n=515/1254)***	***n=439/862***	***n=68/355***	
PTSD, PCL-5 ≥33	24 (4.7%)	20 (4.6%)	4 (5.9%)	0.632
Median (IQR)	5.0 (1.0-12.0)	5.0 (2.0-12.0)	6.0 (1.0-13.8)	0.406
Depression, PHQ-9	***(n=519/1254)***	***n=439/862***	***n=71/355***	0.077
None	331 (63.8%)	283 (64.5%)	40 (56.3%)	
Mild	114 (22.0%)	90 (20.5%)	23 (32.4%)	
Moderate/Severe	74 (14.3%)	66 (15.0%)	8 (11.3%)	
Median (IQR)	3.0 (1.0-7.0)	3.0 (1.0-6.0)	3.0 (1.0-7.0)	0.650
Anxiety, GAD-7	***(n=515/1254)***	***n=436/862***	***n=70/355***	0.944
None	392 (76.1%)	329 (75.5%)	54 (77.1%)	
Mild	79 (15.3%)	69 (15.8%)	10 (14.3%)	
Moderate/Severe	44 (8.5%)	38 (8.7%)	6 (8.6%)	
Median (IQR)	1.0 (0.0-4.0)	1.0 (0.0-4.0)	1.0 (0.0-4.0)	0.897

Cut-off values: SF-12v2 PCS and SF-12v2 MCS < 40, QOLIBRI < 52, PCL-5 ≥ 33, PHQ-9 ≥ 10, GAD-7 ≥ 10; SF-12 PCS = Short Form (12) Health Survey (physical component score); SF-MCS = Short Form (12) Health Survey (mental component score); QOLIBRI = Quality of Life after Brain Injury.
*Glasgow Coma Score (GCS) is missing for 37 (3.0%) patients.

Table 4
Multivariable regression analyses–Odds ratios (OR) for global functional outcome (GOSE), and regression coefficients (B) for generic HRQoL (SF-12v2), disease-specific HRQoL (QOLIBRI-OS), and post-traumatic stress (PCL-5), depression (PHQ-9) and anxiety (GAD-7) symptoms.

	Global functional outcome*	Health-related quality of life*			Psychological symptoms**		
Predictor	**GOSE (1-8) (OR, CI 95%)**	**SF-12 PCS (B, CI 95%)**	**SF-12 MCS (B, CI 95%)**	**QOLIBRI-OS (B, CI 95%)**	**PCL-5 (B, CI 95%)**	**PHQ-9 (B, CI 95%)**	**GAD-7 (B, CI 95%)**
Age ¹	**0.54 [0.44;0.67]**	**-3.22 [-4.83;-1.62]**	-0.44 [-2.17;1.29]	-2.34 [-5.71;1.03]	-0.04 [-1.86;1.77]	0.42 [-0.39;1.23]	0.01 [-0.66;0.68]
Female sex	1.08 [0.84;1.39]	-2.03 [-3.84;-0.01]	-2.11 [-4.05;-0.18]	-3.15 [-6.88;0.59]	1.75 [-0.27;3.78]	1.12 [0.21;2.04]	**0.99 [0.25;1.72]**
High school vs. Primary school	1.18 [0.82;1.71]	2.50 [-0.01;5.01]	**3.69 [1.02;6.37]**	**7.74 [2.59;12.89]**	-3.41 [-6.19;-0.63]	**-1.86 [-3.17;-0.55]**	**-2.12 [-3.20;-1.04]**
Post-high school vs. Primary s.	1.18 [0.81;1.73]	0.96 [-1.65;3.56]	1.02 [-2.12;4.16]	2.49 [-3.66;8.64]	0.05 [-3.13;3.23]	-0.21 [-1.56;1.14]	-1.25 [-2.50;0.01]
College/University vs. Primary s.	1.49 [1.00;2.21]	**4.90 [2.32;7.47]**	3.33 [0.53;6.12]	**6.87 [1.03;12.71]**	-3.15 [-6.20;-0.11]	**-1.81 [-3.14;-0.47]**	**-1.84 [-3.09;-0.59]**
Living alone	1.15 [0.88;1.52]	-0.17 [-2.16;1.81]	-0.73 [-2.83;1.37]	-1.74 [-5.75;2.28]	-1.24 [-3.41;0.94]	0.33 [-0.65;1.31]	-0.65 [-1.44;0.14]
Mild disease vs. Healthy	0.75 [0.55;1.04]	-2.52 [-4.70;-0.35]	-2.51 [-4.82;-0.21]	-5.59 [-10.03;-1.14]	2.14 [-0.24;4.52]	0.77 [-0.30;1.84]	-0.22 [-1.08;0.64]
Severe disease vs. Healthy	**0.53 [0.36;0.79]**	**-5.30 [-8.16;-2.44]**	**-6.13 [-9.15;-3.10]**	**-15.9 [-21.66;-10.14]**	**4.14 [0.95;7.32]**	**2.06 [0.63;3.49]**	0.50 [-0.64;1.64]
Pre-injury psychiatric conditions	**0.54 [0.38;0.76]**	-3.19 [-5.98;-0.40]	**-7.73 [-10.70;-4.75]**	**-11.93 [-17.62;-6.25]**	**5.38 [2.25;8.52]**	**3.80 [2.37;5.23]**	**2.44 [1.29;3.58]**
Prior TBI	1.27 [0.82;1.98]	1.30 [-1.83;4.44]	2.93 [-0.37;6.23]	0.54 [-5.91;6.98]	-2.82 [-6.18;0.54]	-0.45 [-1.98;1.08]	-0.99 [-2.17;0.19]
Anticoagulants/ PAI use	0.76 [0.57;1.00]	-2.26 [-4.25;-0.26]	1.48 [-0.64;3.60]	-0.65 [-4.68;3.38]	-0.18 [-2.39;2.03]	-0.02 [-1.02;0.97]	0.43 [-0.36;1.23]
Beta blocker use	0.80 [0.60;1.07)	-1.68 [-3.90;0.54]	0.73 [-1.57;3.04]	-0.39 [-4.85;4.07]	-0.95 [-3.34;1.44]	-0.49 [-1.59;0.60]	-0.31 [-1.18;0.55]
Intracranial abnormalities	**0.55 (0.42;0.72)**	-0.80 [-2.68;1.08]	0.33 [-1.67;2.33]	-3.99 [-7.81;-0.18]	-0.25 [-2.36;1.86]	0.37 [-0.59;1.33]	0.17 [-0.63;0.97]
Road traffic incident vs. Falls	0.97 [0.72;1.30]	-0.49 [-2.57;1.60]	-1.22 [-3.44;0.99]	-1.61 [-5.86;2.64]	2.20 [-0.11;4.51]	0.28 [-0.76;1.31]	0.32 [-0.52;1.15]
Other vs. Falls	0.81 [0.54;1.23]	-0.47 [-3.29;2.36]	-1.84 [-4.87;1.18]	-2.73 [-8.52;3.05]	3.22 [0.01;6.42]	0.43 [-1.01;1.88]	0.61 [-0.54;1.76]
Glasgow Coma Score (GCS) ¹	**2.31 [1.95;2.73]**	0.55 [-0.83;1.92]	-0.39 [-1.86;1.08]	2.45 [-0.31;5.20]	0.48 [-1.11;2.06]	-0.03 [-0.72;0.67]	0.15 [-0.43;0.73]
Injury severity score (ISS) ¹	**0.50 [0.41;0.60]**	-1.43 [-2.84;-0.01]	**-2.49 [-4.00;-0.99]**	-1.32 [-4.17;1.53]	**2.43 [0.85;4.01]**	0.71 [0.00;1.42]	0.52 [-0.04;1.08]
Measure of performance	C-statistic 0.79	Adjusted R^2 0.19	Adjusted R^2 0.12	Adjusted R^2 0.15	Adjusted R^2 0.08	Adjusted R^2 0.12	Adjusted R2 0.10

¹Continuous predictors scaled by interquartile range that compares the 1st quartile and the 3rd quartile. * Higher score=better outcome. ** Higher score= worse outcome. A p-value <0.05 and a p-value <0.01. GAD-7 = Generalized Anxiety Disorder questionnaire; GOSE = Glasgow Outcome Scale—Extended; PAI=platelets aggregation inhibitor PCL-5 = Posttraumatic Stress Disorder Checklist; PHQ-9 = Patient Health Questionnaire; SF-12 PCS = Short Form (12) Health Survey (physical component score); SF-MCS = Short Form (12) Health Survey (mental component score); QOLIBRI = Quality of Life after Brain Injury.

(SF-12v2 PCS, SF-12v2 MCS, QOLIBRI-OS) scores and higher PCL-5, PHQ-9, and GAD-7 scores for patients aged 85 years and older (Supplementary Figure 1; post-hoc pairwise comparison: **Supplementary Table 2**). The largest difference by age was observed for SF-12v2 PCS with median scores of 46.7 (37.1-52.4) for patients aged 65-74 years, 40.2 (30.6-46.7) for patients aged 75-84 years and 34.7 (24.9-43.6) for patients ≥85 years (p<0.001).

Determinants of outcomes of older patients after TBI

For six-month outcomes, missing values varied from 14% for GOSE to 57%-59% for other outcomes (**Supplementary Table 3**). In multi-variable analyses, lower educational level and pre-injury psychiatric conditions were associated with worse functional outcome, HRQoL and psychological problems (**Table 4, univariable: Supplementary Tables 4-6**). Severe systemic disease was associated with all outcomes except for GAD-7 scores. Higher age was associated with poorer functional outcome (OR (25%:75%) = 0.54, $CI_{95\%}$ [0.44, 0.67] for ordinal GOSE), and SF-12v2 PCS (B (25%:75%) = -3.22, $CI_{95\%}$ [-4.83,-1.62]) but was not significantly associated with other outcomes (Table 4) . Female sex was associated with lower SF-12v2 PCS (B = -2.03, $CI_{95\%}$ [-3.84,-0.01]) and SF-12v2 MCS (B = -2.11, $CI_{95\%}$ [4.05, -0.18]) and higher PHQ-9 (B = 1.12, $CI_{95\%}$ [0.21,2.04]) and GAD-7 (B = 0.99, $CI_{95\%}$ [0.25,1.72]) scores (Table 4). Patients with a higher GCS were more likely to have a higher GOSE (OR (11:15) 2.31, $CI_{95\%}$ [1.95,2.73] for ordinal GOSE; Table 4). There was no significant association between living situation, prior TBI and beta-blocker use with any of the outcomes. The c-statistic of the GOSE ordinal logistic regression model was 0.79. The R^2 for the linear regression models ranged from 0.08 to 0.19 (**Table 4**).

Discussion

We aimed to describe the health care utilization and six-month functional, physical, and mental health of patients aged 65 years and older after TBI. Approximately a third of the TBI patients, consisting mostly of moderate and severe TBI patients, received in-patient rehabilitation. Furthermore, the majority of patients reported remaining disability after 6 months, especially in the functional and physical domain. However, of patients who survived, a substantial number of older patients recovered fully or partially to pre-injury health. HRQoL and mental health symptoms were comparable between patients with mild or moderate/severe TBI. Age and measures of injury severity were primarily associated with functional outcome and physical HRQoL. Systemic disease, pre-injury psychiatric conditions, and lower educational level were predictors of functional impairment, lower HRQoL and mental health 6 months post-injury.

Notably, nearly half of all patients aged ≥ 65 years were admitted to an ICU. An explanation for this relatively high percentage could be inclusion of the entire spectrum of TBI severities and recruitment from large university hospitals and specialized trauma referral centres in the CENTER-TBI study [25]. The mortality rate in older adults (≥65 years) was more than three times as high compared to the younger TBI population (<65 years), which is supported by other studies which found that TBI-related deaths are more likely in older age groups [11,40,41]. The mortality rate was

especially high after moderate/severe TBI (60%), which may be explained by complications, chronic disease, restricted surgical treatment, extra-cranial injuries or biological ageing [42].

The rehabilitation needs in the older TBI population are high and there is a high prevalence of unmet rehabilitation needs [43,44]. Our study showed that just over 60% of the patients after moderate/severe TBI and 22% of patients after mild TBI received inpatient rehabilitation. Previous research reported that older adults received less intensive rehabilitation services than younger patients [21]. However, multiple studies have shown that (aggressive) treatment and rehabilitation benefits older adults, resulting in functional gain and a higher change of being able to return home [45–47]. It is suggested that a presumed poor outcome in older adults leads to reduced management intensity, which subsequently leads to a higher mortality risk [48].

While the mortality and morbidity rates were high, nearly half of older adults with mild TBI still returned to pre-injury functioning and 20% of older adults after moderate/severe TBI did not report severe disability or death. Additionally, health-related quality of life and mental health symptoms were comparable between older patients with mild or moderate/severe TBI.

Impaired mental and disease specific HRQoL were seen in nearly a quarter of older patients, which is comparable to the general TBI population [25]. Impaired physical HRQoL were found in 40% of older TBI patients which is considerably higher than the 29% found in the general TBI population [25]. This could be explained by a higher occurrence of pre-existing comorbidities, a worse pre-injury functional status and physical frailty in older adults. In CENTER-TBI, older adults do not seem to have higher proportions of depression and anxiety than TBI adults in general [49]. This is consistent to previous studies, which found that older adults report less psychological distress than younger adults [14]. However, the proportion of patients with severe depression and anxiety symptoms is higher than in the general population without TBI [50,51]. These long-term impairments in a considerable proportion of older TBI patients underline the importance of appropriate follow-up and treatment of older patients with disability after TBI.

Research on outcome following TBI in older adults has predominantly focused on subgroups of TBI severity and functional outcome [14]. In CENTER-TBI, we found that age and injury characteristics were associated with lower functional outcome but were not significant predictors of mental HRQoL and psychological symptoms when controlled for other important factors. This indicates that older age alone is not sufficient when we want to predict and understand outcomes in older TBI patients, which is in line with previous research suggesting that measures of pre-injury functioning and frailty are more strongly associated with the outcome than the age [12]. One previous study on prognostic factors of poor recovery after TBI in older adults suggested that recovery may be associated more with psychosocial than with biomedical or injury factors [52]. Additionally, previous studies in the adult mild TBI population and the older adult general injury population, showed that those with pre-injury morbidity recovered more slowly [53,54], which is consistent with our findings. These results can eventually be used for targeted rehabilitation programs and prognostic models in order to improve patient outcome. Detailed assessment, inclusion of socio-economic characteristics and pre-injury physical and mental health factors would help to identify older adults with a higher risk of poor outcomes after TBI, who should be monitored and provided early interventions.

This study included a large data sample from multiple European countries in which long-term outcome after TBI in older adults were examined. A variety of both health outcomes and predictors were assessed, including medical history and pharmacotherapy. We also recognize several limitations of our study. First, there are several unmeasured factors including pre- and post-injury frailty, pre-injury HRQoL, mental health at the time of injury, social support and type and frequency of interventions which could be of importance for prediction of outcome in the older population. Moreover, it could explain why the models for mental health domain do not have a high proportion of explained variance.

Second, for several outcome measures at six-months the proportion of missing values was high. Non-responders were older, reported higher pre-injury morbidity, ISS, and GCS and were more likely to be admitted to the ICU. Non-response could therefore be related to the inability to complete the questionnaire due to generally worse pre-injury health, cognitive impairment, or language difficulties. In addition, patients with severe pre-existing neurological disorder were not included.[25] Thus, a subgroup of older patients with profound disabilities was potentially underrepresented, which may be particularly relevant for the moderate/ severe group with a very low response rate. This highlights the importance of adapting the assessments to older patients and patients with disabilities to facilitate their response. Third, this study only included patients with an indication for CT and who presented to university hospitals and specialized trauma centers, which could limit generalizability to older patients with minor TBIs. Finally, the recruitment of patients was not consecutive but influenced by logistic considerations, which might introduced some bias [25].

Conclusions

With an ageing population, the number of older patients who sustain TBI through incidental falls or road traffic incidents will increase, resulting in rising health care utilization and costs, functional impairment, and physical and mental health problems among older adults. There is a need to study TBI in older adults and to develop consensus on management guidelines for this population. This study reported a high mortality rate and a substantial rate of impairments and disabilities following TBI, especially in the functional and physical domain. Nonetheless, a substantial number of older patients recovers to pre-injury health or reports symptoms rates comparable to the general TBI population. The older patients who survive after TBI should receive the treatment and rehabilitation care to help them regain pre-injury health. Moreover, our study found that patient characteristics, including pre-injury systemic disease, pre-injury psychiatric conditions, and lower educational level are important predictors of poorer outcomes. These results underline the importance of a health care assessment in which these predictors are measured. An important overall implication for management of TBI patients in the acute stage is that there should not be pessimism about outcomes in older adults who survive, among which a substantial number fully or partially return to their preinjury functioning.

Ethics approval

The CENTER-TBI study has been conducted in accordance with all relevant laws of the EU if directly applicable or of direct effect, and all relevant laws of the country where the Recruiting sites were located, including, but not limited to, the relevant privacy and data protection laws and regulations (the “Privacy Law”), the relevant laws and regulations on the use of human materials, and all relevant guidance relating to clinical studies from time to time in force including, but not limited to, the ICH Harmonised Tripartite Guideline for Good Clinical Practice (CPMP/ICH/135/95) (“ICH GCP”) and the World Medical Association Declaration of Helsinki entitled “Ethical Principles for Medical Research Involving Human Subjects”. Ethical approval was obtained for each recruiting site. Informed Consent was obtained for all patients recruited in the Core Dataset of CENTER-TBI and documented in the e-CRF. The list of sites, Ethical Committees, approval numbers and approval dates

can be found on the official Center TBI website (www.CENTER-TBI.eu/project/ethical-approval).

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Declaration of Competing Interest

None.

CRediT authorship contribution statement

Marjolein van der Vlegel: Formal analysis, Methodology, Visualization, Writing – original draft. **Ana Mikolić:** Formal analysis, Methodology, Writing – original draft. **Quentin Lee Hee:** Writing – review & editing. **Z.L. Rana Kaplan:** Writing – review & editing. **Isabel R.A. Retel Helmrich:** Writing – review & editing. **Ernest van Veen:** Writing – review & editing. **Nada Andelic:** Writing – review & editing. **Nicole v. Steinbuechel:** Writing – review & editing. **Anne Marie Plass:** Writing – review & editing. **Marina Zeldovich:** Writing – review & editing. **Lindsay Wilson:** Writing – review & editing. **Andrew I.R. Maas:** Project administration, Writing – review & editing. **Juanita A. Haagsma:** Conceptualization, Supervision, Writing – review & editing. **Suzanne Polinder:** Conceptualization, Project administration, Supervision, Methodology, Writing – review & editing.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.injury.2022.05.009.

References

[1] Maas AIR, Menon DK, Adelson PD, Andelic N, Bell MJ, Belli A, et al. Traumatic Brain Injury–Integrated approaches to improve prevention, clinical care, and research. Lancet Neurol 2017;16:987–1048.
[2] Scholten AC, Haagsma JA, Cnossen MC, Olff M, Van Beeck EF, Polinder S. Prevalence of and risk factors for anxiety and depressive disorders after Traumatic Brain Injury–A systematic review. J Neurotrauma 2016;33:1969–94.
[3] Polinder S, Cnossen MC, Real RGL, Covic A, Gorbunova A, Voormolen DC, et al. A multidimensional approach to post-concussion symptoms in mild Traumatic Brain Injury. Front Neurol 2018;9:1113.
[4] Ponsford J, Draper K, Schönberger M. Functional outcome 10 years after Traumatic Brain Injury–Its relationship with demographic, injury severity, and cognitive and emotional status. J Int Neuropsychol Soc 2008;14:233–42.
[5] Roozenbeek B, Maas AIR, Menon DK. Changing patterns in the epidemiology of Traumatic Brain Injury. Nat Rev Neurol 2013;9:231–6.
[6] LeBlanc J, Ed Guise, Gosselin N, Feyz M. Comparison of functional outcome following acute care in young, middle-aged and elderly patients with Traumatic Brain Injury. Brain Inj 2006;20:779–90.
[7] Paget L-M, Boutonnet M, Moyer J-D, Delhaye N, D'Aranda E, Beltzer N, et al. Trauma centre admissions for Traumatic Brain Injury in France–One-year epidemiological analysis of prospectively collected data. Anaesth Crit Care Pain Med 2021;40:100804.
[8] Livingston DH, Lavery RF, Mosenthal AC, Knudson MM, Lee S, Morabito D, et al. Recovery at one year following isolated Traumatic Brain Injury–A Western Trauma Association prospective multicenter trial. J Trauma Acute Care Surg 2005;59:1298–304.
[9] Mushkudiani NA, Engel DC, Steyerberg EW, Butcher I, Lu J, Marmarou A, et al. Prognostic value of demographic characteristics in Traumatic Brain Injury–Results from the impact study. J Neurotrauma 2007;24:259–69.
[10] Mosenthal AC, Livingston DH, Lavery RF, Knudson MM, Lee S, Morabito D, et al. The effect of age on functional outcome in mild Traumatic Brain Injury–6-month report of a prospective multicenter trial. J Trauma Acute Care Surg 2004;56:1042–8.
[11] Hukkelhoven CWPM, Steyerberg EW, Rampen AJJ, Farace E, Habbema JDF, Marshall LF, et al. Patient age and outcome following severe Traumatic Brain Injury–An analysis of 5600 patients. J Neurosurg 2003;99:666–73.
[12] Abdulle AE, de Koning ME, van der Horn HJ, Scheenen ME, Roks G, Hageman G, et al. Early predictors for long-term functional outcome after mild Traumatic Brain Injury in frail elderly patients. J Head Trauma Rehabil 2018;33:E59–67.
[13] Isokuortti H, Iverson GL, Kataja A, Brander A, Öhman J, Luoto TM. Who gets head trauma or recruited in mild Traumatic Brain Injury research? J Neurotrauma 2016;33:232–41.
[14] Hume CH, Wright BJ, Kinsella GJ. Systematic review and meta-analysis of outcome after mild Traumatic Brain Injury in older people. J Int Neuropsychol Soc 2021:1–20.
[15] Lehnert T, Heider D, Leicht H, Heinrich S, Corrieri S, Luppa M, et al. Health care utilization and costs of elderly persons with multiple chronic conditions. Med Care Res Rev 2011;68:387–420.
[16] Keller JM, Sciadini MF, Sinclair E, O'Toole RV. Geriatric trauma–Demographics, injuries, and mortality. J Orthop Trauma 2012;26:e161–e1e5.
[17] Bonne S, Schuerer DJE. Trauma in the older adult–Epidemiology and evolving geriatric trauma principles. Clin Geriatr Med 2013;29:137–50.
[18] Thompson HJ, Weir S, Rivara FP, Wang J, Sullivan SD, Salkever D, et al. Utilization and costs of health care after geriatric Traumatic Brain Injury. J Neurotrauma 2012;29:1864–71.
[19] Hunt C, Zahid S, Ennis N, Michalak A, Masanic C, Vaidyanath C, et al. Quality of life measures in older adults after Traumatic Brain Injury–A systematic review. Qual Life Res 2019;28:3137–51.
[20] Zaninotto AL, Vicentini JE, Fregni F, Rodrigues PA, Botelho C, de Lucia MCS, et al. Updates and current perspectives of psychiatric assessments after Traumatic Brain Injury–A systematic review. Front Psychiatry 2016;7:95.
[21] Gardner RC, Dams-O'Connor K, Morrissey MR, Manley GT. Geriatric Traumatic Brain Injury–Epidemiology, outcomes, knowledge gaps, and future directions. J Neurotrauma 2018;35:889–906.
[22] Maas AIR, Menon DK, Steyerberg EW, Citerio G, Lecky F, Manley GT, et al. Collaborative European NeuroTrauma effectiveness research in Traumatic Brain Injury (CENTER-TBI) a prospective longitudinal observational study. Neurosurgery 2015;76:67–80.
[23] Teasdale G, Jennett B. Assessment of coma and impaired consciousness–A practical scale. Lancet N Am Ed 1974;304:81–4.
[24] Gennarelli TA, Wodzin E. Abbreviated injury scale 2005–Update 2008. Russ Reeder; 2008. 200.
[25] Steyerberg EW, Wiegers E, Sewalt C, Buki A, Citerio G, De Keyser V, et al. Case-mix, care pathways, and outcomes in patients with Traumatic Brain Injury in CENTER-TBI–A European prospective, multicentre, longitudinal, cohort study. Lancet Neurol 2019;18:923–34.
[26] Wilson L, Boase K, Nelson LD, Temkin NR, Giacino JT, Markowitz AJ, et al. A manual for the glasgow outcome scale-extended interview. J Neurotrauma 2021;38:2435–46.
[27] Horton L, Rhodes J, Menon DK, Maas AIR, Wilson L. Collaborative European neurotrauma effectiveness research in TBIP, et al. Questionnaires vs interviews for the assessment of global functional outcomes after Traumatic Brain Injury. JAMA Netw Open 2021;4:e2134121 -e.
[28] Ware JE Jr, Kosinski M, Keller SD. A 12-item short-form health survey–Construction of scales and preliminary tests of reliability and validity. Med Care 1996:220–33.
[29] Ware J, Kosinski M, Turner-Bowker DM, Sundaram M, Gandek B, Maruish ME. User's manual for the SF-12v2 health survey second edition–Qualitymetric incorporated; 2009. Lincoln, RI: QualityMetric.
[30] Von Steinbuechel N, Wilson L, Gibbons H, Muehlan H, Schmidt H, Schmidt S, et al. QOLIBRI overall scale–A brief index of health-related quality of life after Traumatic Brain Injury. J Neurol Neurosurg Psychiatry 2012 ;83:1041–7.
[31] Wilson L, Marsden-Loftus I, Koskinen S, Bakx W, Bullinger M, Formisano R, et al. Interpreting quality of life after brain injury scores–Cross-walk with the short form-36. J Neurotrauma 2017;34:59–65.
[32] Helmrich IRAR, van Klaveren D, Dijkland SA, Lingsma HF, Polinder S, Wilson L, et al. Development of prognostic models for health-related quality of life following Traumatic Brain Injury. Qual Life Res 2021:451–71.
[33] Weathers FW, Litz BT, Keane TM, Palmieri PA, Marx BP, Schnurr PP. The ptsd checklist for dsm-5 (pcl-5). Scale available from the National Center for PTSD at www ptsd va gov. 2013;10.
[34] Stein MB, Jain S, Giacino JT, Levin H, Dikmen S, Nelson LD, et al. Risk of posttraumatic stress disorder and major depression in civilian patients after mild Traumatic Brain Injury–A TRACK-TBI study. JAMA Psychiatry 2019;76:249–58.
[35] Kroenke K, Spitzer RL. The PHQ-9–A new depression diagnostic and severity measure. Psychiatric annals 2002;32:509–15.
[36] Spitzer RL, Kroenke K, Williams JBW, Löwe B. A brief measure for assessing generalized anxiety disorder–The GAD-7. Arch Intern Med 2006;166:1092–7.
[37] von Steinbuechel N, Rauen K, Krenz U, Wu Y-J, Covic A, Plass AM, et al. Translation and linguistic validation of outcome instruments for Traumatic Brain Injury Research and clinical practice–A step-by-step approach within the observational CENTER-TBI study. J Clin Med 2021;10:2863.
[38] Van Buuren S, Groothuis-Oudshoorn K. Mice–Multivariate imputation by chained equations in R. J Stat Softw 2011;45:1–67.

[39] R Core Team. A language and environment for statistical computing, R Foundation for Statistical Computing; 2013. 2020.
[40] de la Plata CDM, Hart T, Hammond FM, Frol AB, Hudak A, Harper CR, et al. Impact of age on long-term recovery from Traumatic Brain Injury. Arch Phys Med Rehabil 2008;89:896–903.
[41] Ratcliff G, Colantonio A, Escobar M, Chase S, Vernich L. Long-term survival following Traumatic Brain Injury. Disabil Rehabil 2005;27:305–14.
[42] McIntyre A, Mehta S, Aubut J, Dijkers M, Teasell RW. Mortality among older adults after a Traumatic Brain Injury–A meta-analysis. Brain Inj 2013;27:31–40.
[43] Andelic N, Røe C, Tenovuo O, Azouvi P, Dawes H, Majdan M, et al. Unmet rehabilitation needs after Traumatic Brain Injury across Europe–Results from the CENTER-TBI Study. J Clin Med 2021;10:1035.
[44] Wilson L, Stewart W, Dams-O'Connor K, Diaz-Arrastia R, Horton L, Menon DK, et al. The chronic and evolving neurological consequences of Traumatic Brain Injury. Lancet Neurol 2017;16:813–25.
[45] Chan V, Zagorski B, Parsons D, Colantonio A. Older adults with acquired brain injury–Outcomes after inpatient rehabilitation. Canadian Journal on Aging/La Revue canadienne du vieillissement. 2013;32:278-86.
[46] Yap SGM, Chua KSG. Rehabilitation outcomes in elderly patients with Traumatic Brain Injury in Singapore. J Head Trauma Rehabil 2008;23:158–63.
[47] Graham JE, Radice-Neumann DM, Reistetter TA, Hammond FM, Dijkers M, Granger CV. Influence of sex and age on inpatient rehabilitation outcomes among older adults with Traumatic Brain Injury. Arch Phys Med Rehabil 2010;91:43–50.
[48] Skaansar O, Tverdal C, Rønning PA, Skogen K, Brommeland T, Røise O, et al. Traumatic Brain Injury–The effects of patient age on treatment intensity and mortality. BMC Neurol 2020;20:1–10.
[49] Teymoori A, Real R, Gorbunova A, Haghish EF, Andelic N, Wilson L, et al. Measurement invariance of assessments of depression (PHQ-9) and anxiety (GAD-7) across sex, strata and linguistic backgrounds in a European-wide sample of patients after Traumatic Brain Injury. J Affect Disord 2020 ;262:278–85.
[50] Hinz A, Klein AM, Brähler E, Glaesmer H, Luck T, Riedel-Heller SG, et al. Psychometric evaluation of the Generalized Anxiety Disorder Screener GAD-7, based on a large German general population sample. J Affect Disord 2017;210:338–44.
[51] Kocalevent R-D, Hinz A, Brähler E. Standardization of the depression screener patient health questionnaire (PHQ-9) in the general population. Gen Hosp Psychiatry 2013;35:551–5.
[52] Kristman VL, Brison RJ, Bédard M, Reguly P, Chisholm S. Prognostic markers for poor recovery after mild Traumatic Brain Injury in older adults–A pilot cohort study. J Head Trauma Rehabil 2016;31:E33–43.
[53] Cassidy JD, Cancelliere C, Carroll LJ, Côté P, Hincapié CA, Holm LW, et al. Systematic review of self-reported prognosis in adults after mild Traumatic Brain Injury–Results of the International Collaboration on Mild Traumatic Brain Injury Prognosis. Arch Phys Med Rehabil 2014;95:S132–SS51.
[54] Sokas C, Herrera-Escobar JP, Klepp T, Stanek E, Kaafarani H, Salim A, et al. Impact of chronic illness on functional outcomes and quality of life among injured older adults. Injury 2021;52:2638–44.