Disorders of Consciousness

Diagnosis, prognostication and counseling, care/treatment, and pediatric considerations for prolonged disorders of consciousness (DoC) in adults and children.

2018 AAN/ACRM/NIDILRR Practice Guideline
Disorders of Consciousness — Update Recommendations Summary
AAN Guideline Development Subcommittee · Neurology
2018;91:450-460

LEVEL · A · Must (Rare, Strongest) · B · Should (Most Common) · C · May (Lowest Allowable)

1 Care Setting & Diagnostic Accuracy

B	**Refer** medically stable patients to specialized multidisciplinary rehabilitation teams.
B	**Assess:** use standardized, validated neurobehavioral tools (e.g., ACRM-recommended); repeat serially to reduce diagnostic error.
B	**Optimize arousal** before assessing consciousness; identify and treat confounders before finalizing diagnosis.
C	**Multimodal testing** may be used (functional imaging/electrophysiology) if awareness remains ambiguous after serial assessments.

2 Prognosis — Timing

A	**Early caution:** avoid statements implying universally poor prognosis within the first 28 days postinjury.
B	**Serial tracking:** perform serial standardized behavioral evaluations to identify the recovery trajectory.
B	**Terminology:** replace "permanent VS" with "chronic VS(UWS)" + duration after 3 months (nontraumatic) or 12 months (traumatic).

3 Prognosis — Tools

B	**Traumatic VS/UWS:** DRS at 2–3 months; MRI at 6–8 weeks (corpus callosum, brainstem, corona radiata); SPECT at 1–2 months.
B	**Nontraumatic VS/UWS:** CRS-R to assist prognostication of 24-month recovery.

4 Prognostic Counseling

B	**Predictors:** MCS within 5 months + traumatic etiology → more favorable; VS/UWS + nontraumatic → poorer, but not universally poor.
A	**Care planning:** once severe long-term disability is likely, direct families to establish goals of care, complete decision-making forms (e.g., MOLST), and start long-term/estate planning.
B	**Chronic phase:** at 3 months (non-TBI) or 12 months (TBI), counsel on likelihood of permanent severe disability and need for long-term care.

5 Care — Preferences, Safety & Pain

A	**Preferences:** identify patient and family preferences early and throughout care to guide decision-making.
B	**Complications:** use systematic assessment to prevent, detect, and treat common early complications.
B	**Pain:** assess and treat suspected pain regardless of consciousness level; counsel families on the uncertainty involved.

6 Pharmacologic & Unproven Treatments

B	**Amantadine:** prescribe 100–200 mg BID for traumatic VS/UWS or MCS at 4–16 weeks postinjury to hasten recovery, if no contraindications.
B	**Unvalidated therapies:** counsel on limited evidence and potential harms; explain uncertainty; note early gains may reflect spontaneous recovery, not the intervention.

7 Children with Prolonged DoC

B	**Diagnosis:** treat confounders, increase arousal, use pediatric-validated tools, and reassess serially.
B	**Prognosis:** natural history and prognosis are not well-defined; no evaluations are established to improve accuracy.
B	**Treatment:** counsel that no established therapies exist for prolonged DoC in children.

Giacino JT, Katz DI, Schiff ND, et al. Practice Guideline Update Recommendations Summary: Disorders of Consciousness: Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the AAN, ACRM, and NIDILRR. *Neurology*. 2018;91(10):450-460.
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