Appendix B: Symptom management[4]

Sign or Sympton	Management
Appetite Changes	**Referral triggers:** Mood, medications, smell and/or other factors can lead to appetite changes. No additional action is needed to manage this symptom specifically as it is a result of secondary issues and will likely resolve when the aforementioned factors are addressed.
Cognitive Symptoms	**Persistent duration:** >30-90 days **Non-pharmacological therapies:** Goal attainment scaling, subsymptom management and exposure are appropriate. An inventory of the activities that are meaningful to the patient's daily activities should be obtained (i.e. increased time reading, working on the computer). Use GAS to develop a baseline of tolerance to these activities and then use exposure to increase their tolerance to the activity. Tasks should be meaningful and directly relevant to the person. Avoid doing memory, problem solving exercises (such as pencil and paper or computer exercises) as they are not associated with improved cognitive functioning. **Referral triggers:** Consider referring patients for a cognitive assessment if functioning is reported to be different than usual (e.g. losing more items than expected or usual and/or memory complaints).
Dizziness and Disequilibrium	**Non-pharmacological therapies:** Vestibular and balance rehabilitation. **Pharmacological therapies:** Medications are not recommended unless symptoms are severe enough to limit functional activities significantly. **Referral triggers:** Once initial primary care assessment for vestibular disturbance is completed, consider referring to a vestibular rehabilitation specialist if other causes are eliminated (e.g. vertebral basilar insufficiency, orthostatic hypotension or polypharmacy).
Fatigue	**Non-pharmacological therapies:** Education (e.g. sleep hygiene and other factors contributing to fatigue), exercise, cognitive behavioural therapy and/or physiotherapy.
Headache (tension-type headache, including cervicogenic component; migraine headaches; or mixed migraine and tension-type headaches)	**Persistent duration:** >3 months **Non-pharmacological therapies:** Relaxation, biofeedback, visualization, extracranial pressure, and thermal therapies. Regular exercise and maintaining consistent sleep and meal schedules can be more preventative than abortive. **Pharmacological treatment:** Medications should be prescribed while keeping in mind the character of the headache. **Referral triggers:** Uncomplicated headaches following mBTI can be addressed in primary care. Consider referring patients to headache specialists or pain treatment programs if there is no or an inadequate response to treatments.
Hearing Difficulties	**Persistent duration:** >30 days **Non-pharmacological therapies:** Pain management, controlling environmental noise, white noise generators. **Referral triggers:** An audiologist referral is indicated for a hearing assessment if persistent and no other apparent cause is found.
Mental Health Symptoms	**Persistent duration:** >30-90 days **Non-pharmacological therapies:** Motivational interviewing and cognitive behavioural approaches would be appropriate. **Referral triggers:** Collaboration with mental health professionals to help reduce distress related to symptoms is indicated.
Nausea	**Non-pharmacological therapies:** Reduce psychological stressors. **Referral triggers:** The initial focus should be on the rapid management of dizziness and return to activity. Specialist assessment should be limited.
Numbness	**Non-pharmacological therapies:** Reduce psychological stressors. **Referral triggers:** Consider performing sensory examination to assess the symptom.
Persistent Pain	**Non-pharmacological therapies:** Rehabilitation therapies. **Pharmacological therapies :** Consider the use of opioid agents only after other avenues of pain management have been explored and given appropriate treatment trials.
Sleep Disturbances	**Pharmacological treatment:** Following mTBI, the use of pharmacological treatment for sleep disturbances may be complicated. Providers should weigh the risk-benefit profiles (e.g. toxicity and abuse potential) prior to initiation of medication.