Appendix 4.1

ICD-10 Definitions for Differential Diagnoses Related to mTBI

Depressive Episode (F32)	In typical mild, moderate, or severe depressive episodes, the patient suffers from lowering of mood, reduction of energy, and decrease in activity. Capacity for enjoyment, interest and concentration is reduced, and marked tiredness after even minimum effort is common. Sleep is usually disturbed and appetite diminished. Self-esteem and self-confidence are almost always reduced and, even in the mild form, some ideas of guilt and worthlessness are often present. The lowered mood varies little from day to day, is unresponsive to circumstances and may be accompanied by so-called "somatic" symptoms, such as loss of interest and pleasurable feelings, waking in the morning several hours before the usual time, depression worst in the morning, marked psychomotor retardation, agitation, loss of appetite, weight loss, and loss of libido. Depending upon the number and severity of symptoms, a depressive episode may be specified as mild, moderate or severe. *Includes:* Single episodes of: • Depressive reaction • Psychogenic depression • Reactive depression *Excludes:* • Adjustment disorder • Recurrent depressive disorder • When associated with conduct
Organic Anxiety Disorder (F06.4)	A disorder characterized by the essential descriptive features of a generalized anxiety disorder (see below), a panic disorder (see below), or a combination of both, but arising as a consequence of an organic disorder. *Excludes*: Anxiety disorders, nonorganic or unspecified
Generalized Anxiety Disorder (F41.1)	Anxiety that is generalized and persistent but not restricted to, or even strongly predominating in, any particular environmental circumstances (i.e., it is "free-floating"). The dominant symptoms are variable but include complaints of persistent nervousness, trembling, muscular tensions, sweating, lightheadedness, palpitations, dizziness, and epigastric discomfort. Fears that the patient or a relative will shortly become ill or have an accident are often expressed. *Anxiety* (Neurosis, Reaction, State) *Excludes*: Neurasthenia
Panic Disorder (F41.0)	The essential feature is recurrent attacks of severe anxiety (panic), which are not restricted to any particular situation or set of circumstances and are therefore unpredictable. As with other anxiety disorders, the dominant symptoms include sudden onset of palpitations, chest pain, choking sensations, dizziness, and feelings of unreality (depersonalization or derealization). There is often also a secondary fear of dying, losing control, or going mad. Panic disorder should not be given as the main diagnosis if the patient has a depressive disorder at the time the attacks start; in these circumstances the panic attacks are probably secondary to depression. *Panic* (Attack, State) *Excludes*: Panic with agoraphobia
Post Traumatic Stress Disorder (F43.1)	Arises as a delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. Predisposing factors, such as personality traits (e.g., compulsive, asthenic) or previous history of neurotic illness, may lower the threshold for the development of the syndrome or aggravate its course, but they are neither necessary nor sufficient to explain its occurrence. Typical features include episodes of repeated reliving of the trauma in intrusive memories ("flashbacks"), dreams or nightmares, occurring against the persisting background of a sense of "numbness" and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma. There is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. The onset follows the trauma with a latency period that may range from a few weeks to months. The course is fluctuating but recovery can be expected in the majority of cases. In a small proportion of cases the condition may follow a chronic course over many years, with eventual transition to an enduring personality change.

Persistent Somatoform Pain Disorder (F45.4)	The predominant complaint is of persistent, severe, and distressing pain, which cannot be explained fully by a physiological process or a physical disorder, and which occurs in association with emotional conflict or psychosocial problems that are sufficient to allow the conclusion that they are the main causative influences. The result is usually a marked increase in support and attention, either personal or medical. Pain presumed to be of psychogenic origin occurring during the course of depressive disorders or schizophrenia should not be included here. Psychalgia; Psychogenic (Backache, Headache); Somatoform pain disorder *Excludes*: • Backache NOS • Pain (NOS, Acute, Chronic, Intractable) • Tension headache
Whiplash Associated Disorder (S13.4)	**Sprain and Strain of Cervical Spine** Anterior longitudinal (ligament), cervical Atlanto-axial (joints) Atlanto-occipital (joints) Whiplash injury
Substance Dependence Syndrome (F19.2)	A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state. The dependence syndrome may be present for a specific psychoactive substance (e.g., tobacco, alcohol, diazepam), for a class of substances (e.g., opioid drugs), or for a wider range of pharmacologically different psychoactive substances. *Excludes*: • Backache NOS • Pain (NOS, Acute, Chronic, Intractable) • Tension headache
Factitious Disorder (F68.1)	The patient feigns symptoms repeatedly for no obvious reason and may even inflict self-harm in order to produce symptoms or signs. The motivation is obscure and presumably internal with the aim of adopting the sick role. The disorder is often combined with marked disorders of personality and relationships. Hospital hopper syndrome; Münchhausen's syndrome; Peregrinating patient *Excludes*: • Factitial dermatitis • Person feigning illness (with obvious motivation)
Malingering (Z76.5)	Person feigning illness (with obvious motivation). *Excludes*: • Factitious disorder • Peregrinating patient
Somatoform Disorder (F45.0)	The main feature is repeated presentation of physical symptoms together with persistent requests for medical investigations, in spite of repeated negative findings and reassurances by doctors that the symptoms have no physical basis. If any physical disorders are present, they do not explain the nature and extent of the symptoms or the distress and preoccupation of the patient. *Excludes*: • Dissociative disorders • Hair-plucking • Lalling • Lisping • Nail-biting • Psychological or behavioural factors associated with disorders or distress classified elsewhere • Sexual dysfunction, not caused by organic disorder or disease • Thumb-sucking • Tic disorders (in childhood and adolescence) • Tourette's syndrome • Trichotillomania