Background: A 21 year old male collegiate football running back with a history of traumatic brain injury from the previous spring season complained of headache, nausea, and sensitivity to light two days after the first fall pre-season scrimmage. In regards to the previous spring injury, the athlete experienced a forceful head collision resulting in a mild headache and tinnitus that he equated as a normal response to minor head trauma. These symptoms did not warrant the athlete’s concern until it persisted for approximately four weeks. Upon seeking medical attention, an MRI and CT scan were preformed and the athlete was diagnosed with a left temporal pole and right frontal temporal pair of subdural hematomas. He was restricted from activity for approximately two months until signs and symptoms had ceased and a follow-up MRI revealed that the blood had been reabsorbed. At approximately 18 weeks, the start of fall season, the athlete was cleared to return to contact activities. Two days after the first fall scrimmage, five months post injury; the athlete reported that he was experiencing nausea, vomiting, diarrhea, photophobia and a severe headache. He could not recall any traumatic blow to the head or tackle and upon review of the video tape from the scrimmage it was agreed that there was no major incident of head trauma. The athlete refused to take HeadMinder, a neurocognitive assessment for concussion because it would have been unbearable for him to focus and stare at a computer screen for an extended period. In lieu of his history, the athlete was sent to the ER. Differential Diagnoses: The clinical impression at this time of initial evaluation was concussion, second-impact syndrome, heat illness, epidural hematoma or the recurrence of a subdural hematoma. Treatment: The CT Scan was positive for a right frontal subdural hematoma and the athlete was prescribed medications for anti-seizure nausea. Multiple pain medications were administered to no avail, until oxycontin was successful in alleviating a minimal amount of pain, however, the medication was unsuccessful in decreasing all of the pain and discomfort and he was subsequently placed in a dark room to try and ease his photophobia. The athlete spent two nights in the hospital under observation, before being released to the university’s overnight health clinic. He spent two subsequent weeks at the clinic, until signs and symptoms had subsided. Severe headaches and photophobia were among the most prominent lingering symptoms. The athlete currently remains under close observation by his doctors. Uniqueness: This injury is unique because subdural hematomas are more commonly associated with a traumatic mechanism not involving the protection of a helmet such as a motor vehicle accident. Even though proper protocol was followed, this athlete had experienced a high series of subdural hematomas. This last injury occurred with minimal contact and is an unlikely diagnosis from the average contact forces imparted during football. Conclusion: The athlete will not return to collegiate athletics due to both the severity and repetitive nature of this injury. It is important to stress the value of athlete education on how even a mild headache should not be ignored. Since this is a unique head injury for a football player, it may be an indication of the importance of universal return to play guidelines. Currently there are no definitive guidelines in place regarding return after a subdural hematoma. The athlete’s return is left up to the discretion of each doctor. In
light of the potential gravity that can develop from a subdural hematoma, this case study may illustrate the importance of developing a set of guideline to help direct other clinicians in their treatment protocols.

**Word Count: 600**