Closed head trauma and aphasia

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SUMMARY A prospective study has been done on the relationship between closed head trauma and aphasia. The most frequent type of aphasia seen after closed head injury is an anomic aphasia. This aphasia is often associated with other defects of higher cortical function. The second most common type of aphasia is a Wernicke’s aphasia. Other types of aphasia were not seen in this study. The areas of the head which when injured produce aphasia are the right orbitofrontal region and the left temporoparietal region. The prognosis for recovery appeared highly variable.

Brain (1965) records that Valerius Maximus (30 A.D.) described a learned man of Athens who lost his memory for words after being struck on the head with a stone. Although the association of language disorder with head trauma was known even to the ancients, there are even now few detailed descriptions of aphasia after closed head injuries. Goldstein (1942), Schiller (1947), Russell and Espir (1961), and Walker (1968) have written about injuries that resulted in aphasia and other defects of higher cortical function, but these injuries were, for the most part, penetrating wounds. There have been cases of closed head injury and aphasia reported in the literature by Lichtheim (1885), Russell (1932), and Perlo and Schwab (1969), but these have been single case reports and in most the aphasia was reported merely as an accessory finding. Goldstein (1948) studied a woman who had suffered head trauma and had anomic aphasia, but despite the history of trauma, he attributed the defect to arteriosclerosis. Glaser and Shafer (1932) studied 255 patients with head trauma from non-penetrating wounds. Sixteen of these cases developed aphasia. One of the 16 had a ‘complete motor aphasia’. Ten patients had a ‘partial motor aphasia’, four had a ‘mixed sensory and motor aphasia’, and one had a ‘pure sensory aphasia’. The authors did not mention how they examined their patients for aphasia or on what basis they were classified. Included in this series of patients were cases with depressed fractures, abscesses, and intracerebral haematomas. Although these authors studied the relationship between the location of the injury and other signs and symptoms, they did not do this for their cases of aphasia.

The purpose of this study, therefore, was to do a prospective investigation on the relationship between closed head trauma and aphasia.

METHODS

During a 10 month period adult patients admitted to the Boston City Hospital with a diagnosis of head trauma were screened for aphasia and other defects of higher cortical function. Patients admitted with the diagnosis of head trauma were usually admitted because of unconsciousness or history of previous unconsciousness, the presence of a skull fracture or evidence of extensive soft tissue injury, neurological signs, or evidence of severe injury to other parts of the body. The aphasia screening examination, which was not done until the patient was alert and cooperative, consisted of evaluation of spontaneous speech, comprehension of spoken and written language, repetition, naming, ability to write, calculation, right-left orientation, and finger recognition. If a patient showed any defect on this screening test he was given a more detailed aphasia examination as well as a thorough neurological examination. The period of unconsciousness as well as the severity and area of head injury were noted. All other pertinent clinical and laboratory data were recorded and patients were followed until their aphasia cleared or they were lost to follow-up. Patients were excluded from this series if there was no clear history or evidence for head trauma. They were excluded if they did not have aphasia before a seizure or if they did not persist at least a week after a seizure. Patients with subdural haematomas were included only if the aphasia persisted after operation, and there was evidence that the cerebrum was not damaged by the removal. Patients with depressed

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intracerebral fractures, intracerebral abscesses, and cases in which there was operative intervention with manipulation of the cerebrum were also excluded from our series.

We classified our aphasics according to the Benson and Geschwind (1971) classification. Anomic aphasia was defined as a fluent aphasia in which the patient demonstrates verbal paraphasias and circumlocutions, has normal comprehension and repetition, and has abnormal naming for all kinds of material especially to confrontation. Wernicke's aphasia was defined as a fluent aphasia with paraphasia, poor comprehension for spoken and written language, and poor repetition. Broca's aphasia was defined as non-fluent aphasia with good comprehension, which may improve slightly in repetition, series speech, and singing. Global aphasia was defined as a non-fluent aphasia with poor comprehension, poor repetition, and poor naming. Conduction aphasia was defined as a fluent aphasia with literal paraphasia, good comprehension, but very poor repetition, and impaired naming. We defined the syndrome of the isolated speech area as a fluent aphasia with poor comprehension, but with excellent repetition and echolalia.

The location and severity of the major area injured in 100 cases of head trauma requiring admission, but without aphasia, were examined in order to compare the areas injured in this non-aphasic group to the areas injured in the aphasia group.

RESULTS

During the 10 months this study took place, approximately 750 patients were admitted to the Boston City Hospital with a diagnosis of closed head trauma. Of this group there were 15 cases of aphasia after closed head trauma. Two cases were excluded, and 13 met our criteria for inclusion. One excluded case was a patient who had an anomic aphasia while lethargic, but in whom when he became alert no aphasia could be detected. The second patient excluded had a persistent anomic aphasia but had had his anterior temporal lobe needle by the neurosurgeons before he was examined for aphasia.

The mean age of the aphasic group was 57, and the mean age in the control group with closed head injury but without aphasia was 43. In the group of 13 aphasic patients there were six known alcoholics. Previous studies have shown that of the entire patient population of this hospital approximately 20% are known alcoholics, while among patients with head injuries in this institution the figure is much higher.

Seven of the 13 patients with aphasia had evidence of right orbitofrontal trauma, four had evidence of trauma in the left temporoparietal region, and two had no external evidence of trauma (Table 1). In the nonaphasic, or control group, 27 of the 100 cases with closed head trauma had evidence of trauma to the right orbitofrontal region, 29 to the left orbitofrontal region, nine to the right temporoparietal region, nine to the left temporoparietal region, six to the right occipital region, six to the left occipital region, and 14 either had no evidence of injury or were injured in the midline, on the nose, or on the mandible (Table 2).

We will now give three illustrative cases.

CASE 1

(BCH no. 2109370) Four days before admission this 57 year old alcoholic female had been beaten over the head by thieves. After this episode the patient's landlord noticed that the patient was 'talking funny', but did not become concerned until the day of admission when the patient had a major motor seizure and was admitted to Boston City Hospital.

Three days after her admission, the patient was transferred to the Neurological Unit. General physical examination revealed hepatomegaly. There was no external evidence of head trauma. On neurological examination she was alert and cooperative. She is right handed and a high school graduate. She was oriented to place, person, and year. She did not know the month or day. Her memory for recent events was poor and she could recall only one out of three objects in three minutes. On aphasia examination her spontaneous speech was fluent, but contained circumlocutions and empty phrases, while comprehension and the ability to repeat verbal material appeared normal. Her major difficulty was in naming objects. She could, however, tell what these objects were used for and she could select the correct name if given a choice. The patient could not read aloud, or show comprehension of written language, whether tested by commands, yes-no and multiple-choice questions, pointing or skin galvanometry. She could not recognize words, syllables, or letters visually or tactually. She had difficulty in recognizing words that were spelled to her but could spell when given words. Her writing, both spontaneous and to command, was excellent. She wrote well to dictation and could copy, but she could not...
read what she had written. Although the patient could match colours well she could not name them correctly even when the answers were given in the form of a multiple-choice question. When asked to name colours from memory she did well. The patient confused her right and left, could not name her fingers, even when given the name in a multiple-choice question, and could not move the finger the examiner requested her to move or even point to the correct finger. Her calculations were poor and she did not correct with multiple-choice questions. Her drawings of cubes, clocks, and flowers were normal and the patient never demonstrated a hemianopsia.

The patient had a lumbar puncture which showed xanthochromic fluid but was under normal pressure and contained no cells. Her EEG, brainscan, and left carotid arteriogram were all normal.

She was discharged one month after her admission and at the time of her discharge her findings were essentially unchanged.

The patient was seen in clinic eight months after discharge. Her anomic aphasia persisted, and although she could read occasional letters and words she remained dyslexic. Her writing remained normal and she no longer showed right-left confusion, finger agnosia, and acalculia. The remainder of her examination was unchanged.

**CASE 2**

(BCH no. 2011891) An 80 year old right-handed woman had been in good health except for decreased vision which resulted from advanced glaucoma. On the way to church she tripped, fell, injured her head, and was knocked unconscious. When admitted to Boston City Hospital, however, she was noted to be lethargic and aphasic.

A consultant from the Neurological Unit examined her on the following day and noted that the patient had a large contusion over the left parietal area. Although the patient appeared alert her intellectual function could not adequately be tested because of severe aphasia. Her speech was fluent and she would not even stop speaking when the examiner asked her to stop. Her speech was markedly paraphasic and contained many neologisms. She showed no evidence that she could comprehend written or spoken language. She would not repeat, name, do series speech or write. On examination of the cranial nerves there was a questionable decrease of blink on the right side but no consistent field defect could be obtained. The patient moved the right side slightly less than the left and she had a right-sided extensor plantar response. Her cerebrospinal fluid contained 35,000 erythrocytes/cu. mm and skull radiographs showed a left temporal-parietal linear non-displaced fracture.

The patient regained her strength on her right side, but when discharged on the 32nd day she remained severely aphasic.

**CASE 3**

(BCH no. 2109684) A 56 year old right handed male alcoholic was beaten on the head during a mugging. He was unresponsive on admission, but shortly after admission he awoke, was noted to be aphasic, and was transferred to the Neurological Unit.

On admission to the Unit it was noted that the patient had a contusion over the right orbit and a right conjunctival haemorrhage. On neurological examination it was noted that the patient was alert and fully oriented. While he could not remember the events which surrounded his injury, he could recall three objects in three minutes and seemed to have a good recent memory. The remainder of his intellectual functions were unremarkable. On aphasia testing the patient's spontaneous speech was fluent, but contained frequent circumlocutions and empty phrases. His comprehension of spoken language was excellent as was his repetition. He exhibited a major difficulty in naming. While he could not name objects he saw or touched he could tell what they were used for, and could select the correct name if given in a multiple-choice fashion. The patient showed little evidence that he comprehended the written material. His writing, both to dictation and spontaneously, was also extremely poor. The patient did not demonstrate acalculia, finger agnosia, or right-left confusion. Other than decreased pin prick sensation in a stocking-like distribution and decreased ankle jerks the remainder of the neurological examination was normal.

The patient's lumbar puncture, skull radiographs, and EEG were all normal.

He remained in the hospital for 22 days and during this time his clinical picture remained unchanged. Five months after his discharge he was seen in a local tavern by a physician from the Neurological Unit. The patient recognized him, came over to the physician and asked, 'Do you have a ... You know what I mean. A thing to buy a drink with?'

**DISCUSSION**

There were only two types of aphasia seen after closed head injury. Nine patients had a classical anomic aphasia and four had a Wernicke's aphasia (Table 3). No other type of aphasia was seen.

We found three additional cases of anomic aphasia secondary to closed head trauma but since these patients had their trauma before the time this study was started they were not included.

Weinstein and Kahn (1952) and Weinstein and Keller (1963) described a naming defect seen in

<table>
<thead>
<tr>
<th>Type of aphasia</th>
<th>Aphasic patients (no.)</th>
<th>Aphasic patients (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wernicke's aphasia (sensory aphasia, receptive aphasia)</td>
<td>4</td>
<td>30.7</td>
</tr>
<tr>
<td>Anomic aphasia (amnestic, nominal)</td>
<td>9</td>
<td>69.3</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>100</td>
</tr>
</tbody>
</table>
diffuse brain disease, including head trauma. Their patients substituted names of objects related to their illness for correct names. This defect was associated with behavioural changes such as delusions and disorders of mood. The authors, therefore, called this defect non-aphasic misnaming. Geschwind (1967) notes that these errors in naming often ‘propagate’. ‘He may call the hospital “hotel”, doctors “bell-boys”, and the nurses “chambermaids”.’ This non-aphasic misnaming is unstable and the spontaneous speech is often normal despite gross errors in naming. Unlike the patients with non-aphasic misnaming, our patients had difficulty in naming all types of material and did not tend to substitute name of objects related only to their illness. There were no gross behavioural changes and no tendency to propagate. Many of our patients had stable defects and both spontaneous speech and writing were often involved in the naming disorder. Among the varieties of naming defects described by Geschwind (1967), it appears that our patients had a classical anomic aphasia.

Seven of the aphasic patients had mild motor signs; five had seizures and one had a hemianopsia. A post-traumatic Korsakoff’s syndrome was seen in four of the nine patients with anomic aphasia and the memory defect returned to normal in all four. Six out of the nine patients with anomic aphasia had some additional defect of higher cortical function, including right-left confusion, finger agnosia, dyscalculia, dysgraphia, and dyslexia (Table 4). In this respect case 1 is of special interest in that, in addition to an anomic aphasia, she presented with a severe alexia without agraphia and without a right hemianopsia. Alexia without agraphia has been recognized for many years, especially since the first post-mortem report by Dejerine (1892). Almost all of the cases of this syndrome have an associated right hemianopsia.

Most of the cases of alexia without agraphia have the ability to read material which is presented non-visualy. When letters are spelled out or written on the patient’s hand, the patient is usually able to read. Case 1 could not read by auditory or somaesthetic means, and in this respect was similar to cases of alexia with agraphia. Our patient had difficulty in naming colours even when the names were presented in a multiple-choice fashion. She had no difficulty in matching colours, and in this respect she was similar to cases of alexia without agraphia.

The aetiology of most of the reported cases has been vascular occlusion of the posterior cerebral artery producing an infarction of the dominant occipital lobe and the callosal connections from the non-dominant occipital lobe to the speech area. While Adler (1944) and Alajouanine, Lhermitte, and de Ribaucourt-Ducarne (1960) have reported cases without hemianopsia, Benson and Geschwind (1969) stated that there have been no well-documented cases, with or without hemianopsia, that have resulted from trauma.

The patients who developed aphasia after head injury had a different distribution of the injured areas on the head than did the patients with head trauma without aphasia. Patients with aphasia had their heads injured in either the right orbitofrontal or left temporoparietal regions (Table 1), while the nonaphasic patients, or control group, had almost an equal distribution of trauma between the right and left sides in the orbitofrontal and temporoparietal regions. It therefore appears that patients who receive head trauma to the right orbitofrontal and left temporoparietal regions are more likely to develop post-traumatic aphasia than patients with trauma to other parts of the head. The preponderance of right orbitofrontal trauma in our aphasic patients is probably somewhat dependent on the higher incidence of frontal trauma in our popula-

**TABLE 4**

**ADDITIONAL DEFECTS OF HIGHER CORTICAL FUNCTION**

<table>
<thead>
<tr>
<th>Case no.</th>
<th>Type of aphasia</th>
<th>Area of external injury</th>
<th>Korsakoff’s syndrome</th>
<th>Dyslexia</th>
<th>Dysgraphia</th>
<th>R-L confusion</th>
<th>Finger agnosia</th>
<th>Dyscalculia</th>
<th>Constructional apraxia</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Anomic</td>
<td>None</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>Wernicke’s</td>
<td>L temporoparietal</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>3</td>
<td>Anomic</td>
<td>R orbitofrontal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>Anomic</td>
<td>R orbitofrontal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>5</td>
<td>Anomic</td>
<td>R orbitofrontal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>6</td>
<td>Wernicke’s</td>
<td>R orbitofrontal</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
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<tr>
<td>7</td>
<td>Wernicke’s</td>
<td>L temporoparietal</td>
<td>—</td>
<td>—</td>
<td>—</td>
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<td>—</td>
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<td>—</td>
</tr>
<tr>
<td>8</td>
<td>Anomic</td>
<td>L temporoparietal</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>9</td>
<td>Anomic</td>
<td>L temporoparietal</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>10</td>
<td>Wernicke’s</td>
<td>R orbitofrontal</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
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</tr>
<tr>
<td>11</td>
<td>Anomic</td>
<td>None</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
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</tr>
<tr>
<td>12</td>
<td>Anomic</td>
<td>R orbitofrontal</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>13</td>
<td>Anomic</td>
<td>R orbitofrontal</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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</table>
tion, in addition to a selective vulnerability of the right orbitofrontal region as compared with the left.

Courville (1942) and others have noted that the dorsolateral surface of the temporal lobe was a frequent site of contusion, whereas other regions of the speech area, including the frontal and parietal opercula, were rarely contused. In our series, a parietal lobe contusion was seen in one case at post-mortem examination and in another case a contusion of the dorsolateral temporal lobe was seen during the removal of a subdural haematoma. Several other cases had arteriography which suggested swelling of the temporal lobe. Most of our cases have had either bloody or xanthochromic spinal fluid. Although the pathology of all these cases of post-traumatic aphasia is not known, it appears that contusion of the dorsolateral surface of the temporal lobe and temporoparietal junction is the most likely aetiology for these aphasias.

It is not known for certain why trauma in the same area of the head produces an anomic aphasia in some patients, a Wernicke's aphasia in others, and in some it produces no aphasia. There very well may be a difference in the severity of the trauma or a small difference in the area injured. We were, however, unable to measure these differences in our material.

Although we had some difficulties with long term follow-up, a problem peculiar to our institution and patient population, in our cases recovery varied greatly and we could find no constant relationships that would help the physician to prognosticate.

REFERENCES


