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Abstract

This article conducts a contemporary comparative review of the medical literature to update and establish evidence as to which framework among Rotterdam and Marshall computed tomography (CT)-based scoring systems predicts traumatic brain injury (TBI) outcomes better. The scheme followed was following the recommendations of the Preferred Reporting Items for Systematic Reviews and Meta-Analysis guidelines for literature search. The search started on August 15, 2020 and ended on December 31, 2020. The combination terms used were Medical Subject Headings terms, combination keywords, and specific words used for describing various pathologies of TBI to identify the most relevant article in each database. PICO question to guide the search strategy was: “what is the use of Marshall (I) versus Rotterdam score (C) in TBI patients (P) for mortality risk stratification (O).” The review is based on 46 references which included a full review of 14 articles for adult TBI patients and 6 articles for pediatric TBI articles comparing Rotterdam and Marshall CT scores. The review includes 8,243 patients, of which 2,365 were pediatric and 5,878 were adult

Keywords

► scoring systems
► traumatic brain injury
► Rotterdam score
► Marshall score
► CT-based scoring
TBI patients. Marshall CT classification is not ordinal, is more descriptive, has better inter-rater reliability, and poor performance in a specific group of TBI patients requiring decompressive craniectomy. Rotterdam CT classification is ordinal, has better discriminatory power, and a better description of the dynamics of intracranial changes. The two scoring systems are complimentary. A combination of clinical parameters, severity, ischemic and hemodynamic parameters, and CT scoring system could predict the prognosis of TBI patients with significant accuracy. None of the classifications has good evidence for use in pediatric patients.

## Introduction

Traumatic brain injury (TBI) is a leading cause of morbidity and mortality in trauma patients and is a major public health concern globally by affecting the younger age group. Clinical outcomes of TBI is multifactorial and varies across institutions, regions, age groups, and health care systems. Due to the malignant nature of TBI, various prediction and prognostic models are in use for resource allocation, prediction of clinical outcome at the time of admission, decision making, and family counseling. Results of the IMPACT study group showed that computed tomography (CT) characteristics have highest prognostic value after clinical severity. Marshall (1995) and Rotterdam CT (2005) scoring systems are two most commonly used to predict clinical outcome in TBI patients. Recently, many studies were conducted to evaluate the comparative efficacy of the two prediction models. Each of these models aims at improving the outcome prediction and has their own sets of limitations. Since guidelines for surgery in TBI patients is not uniform worldwide, two major limitations of Marshall scoring is stated as the division of hematoma based on volume and surgical evacuation. Additionally, there is existing literature in favor of either of the scoring system and there is no conclusive evidence as to which scoring systems has better predictive power. Therefore, this comparative review aims to summarize and update the available evidence from existing studies of the predictive value of Marshall and Rotterdam CT scoring system in predicting clinical outcome in TBI patients.

## Methods

We conducted this comparative review based on the Preferred Reporting Items for Systematic Reviews and Meta-Analysis statement guidelines to ensure a high-quality study. A systematic and comprehensive literature search was conducted in the electronic database of PubMed and Scopus to identify cohort, prospective, observational studies, and randomized clinical trials (RCTs) on validation of Rotterdam score and Marshall score for mortality risk stratification within 6 months in TBI patients. The search started on August 15, 2020 and ended on December 31, 2020. The combination terms used were Medical Subject Headings (MeSH) terms, combination keywords, and specific words used for describing various pathologies of TBI to identify the most relevant article in each database. PICO question to guide the search strategy was: “what is the use of Marshall (I) versus Rotterdam score (C) in TBI patients (P) for mortality risk stratification (O).” An example of the search strategy used in PubMed was: “patients[All Fields]) AND (“pediatrics”[All Fields] OR “pediatrics”[MeSH Terms] OR “pediatrics”[All Fields]) AND (“child”[MeSH Terms] OR “child”[All Fields] OR “children”[All Fields]) AND (“traumatic brain injury”[MeSH Terms] OR “traumatic brain injury”[All fields]) AND (“mortality risk stratification”[All fields]) OR (“Rotterdam score”[All Fields] OR “Marshall score”[All fields]) NOT (“Helsinki score”[MeSH Terms] OR “Helsinki score”[All Fields])). All patients included were diagnosed by CT scans. Studies with pediatrics patients and studies on the scoring system other than Marshall and Rotterdam CT scoring system were excluded from this review. Articles were reviewed by two authors to identify studies in which patients with TBI were diagnosed by CT and mortality risk stratification was performed by Marshall and Rotterdam score. Authors independently reviewed initially titles and abstracts and then full texts of remaining articles and results. The references were studied to identify other prospective studies. No assessment of quality and risk of bias was done and no study was excluded based on quality.

## Results

This review is based on a comparison of the predictive value of Rotterdam and Marshall CT score in predicting clinical outcome in TBI patients (Table 1). A total of 63 (n = 63) studies were retrieved using the search criteria and screened for potential eligibility. The studies comparing the predictive value of two scoring systems or assessment of the scoring system in the pediatric age group were considered for this review. This review was based on 46 referenced article, including 14 citations on comparison of the two scoring system and 6 citations on use of Rotterdam and Marshall CT scoring system in pediatric TBI patients. There were no systematic review, meta-analysis, or RCT found. The review includes 8,243 patients, of which 2,365 were pediatric and 5,878 were adult TBI patients. Characteristics of studies including adult patients and pediatric patients are as shown in Table 2, respectively.
Discussion

Prediction Models in TBI
TBI accounts for significant mortality, morbidity, and economic burden globally. It was found in a systematic review that economically productive young age group have a particularly high incidence of TBI. On the other hand, individuals in extremes of age sustaining TBI have more severe injuries and the likelihood of poorer outcomes. Several classification systems are in use to classify TBI based on clinical and radiological parameters. These classification systems aim to prognosticate the outcomes of TBI. However, there is no classification system which is comprehensive and inclusive of all predictors. Clinical complications of a TBI can lead from a compressive brain syndrome, and consequently, intracranial hypertension. Massive hemorrhage depending on the degree of TBI may end in hypovolemic shock and worsen the prognosis of patients. Therefore, it is important to have a scale that correctly classifies the prognosis of patients with TBI and thus be able to take the correct measurements. Mayo classification system devised a classification for TBI with a sensitivity of 89% and specificity of 98% by including multiple predictors in the classification system. Clinically, Glasgow Coma Scale (GCS) and Glasgow Outcome Scale (GOS) are used to assess the severity and prognosticate brain injury. However, it is difficult and, in some cases, impossible to determine GCS, since many patients are intubated, sedated, intoxicated, or unable to speak or move. Therefore, CT is the recommended evaluation method of choice. In 1991, an image prognostic scale was first described by Marshall et al, according to many characteristics assessed in CT brain. This classification system is considered a gold standard in TBI classification. International guidelines on the prognosis of severe TBI states class I evidence for Marshall CT scoring as a major CT prognostic model in TBI patients. However, it has limitations for space-occupying injuries. Accordingly, in 2005, Maas et al determined a new prognostic classification by imaging that includes basal cisterns, midline, epidural hematoma, intraventricular, or subarachnoid hemorrhage (SAH), generating greater validation to define the mortality risk stratification or prognosis. One of the major differences between these two classifications is that Rotterdam CT classification is stand-alone and does not require any intervention as one of the parameters in contrast to Marshall score where evacuation of mass lesion is one of the measurements. The predictive power of these scoring systems depends on the outcome measured. Both the scoring system has a similar mortality prediction but only Rotterdam scoring correlation with predicted outcome measured as GOS. Also, none of the two scorings were found to have significant predictive power for outcome evaluated as Functional Independence Measure motor or cognitive domain at discharge or 9 months’ follow-up, though specific scores (Marshall 3 and 5, Rotterdam 5 and 6) were able to predict these outcomes and length of stay. This study aimed to conduct a comparative review to establish the existing evidence for the predictive power of Rotterdam and Marshall scoring system in mortality risk stratification of TBI patients.

Table 1 Differences between Marshall and Rotterdam CT classification

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Marshall CT classification</th>
<th>Rotterdam CT classification</th>
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<tbody>
<tr>
<td>1.</td>
<td>More descriptive</td>
<td>More discriminative</td>
</tr>
<tr>
<td>2.</td>
<td>Lacks individual CT charact</td>
<td>Individual CT characteristics present</td>
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<tr>
<td>3.</td>
<td>Predictive value is similar</td>
<td>Predictive value is simila</td>
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<tr>
<td></td>
<td>to Rotterdam CT score</td>
<td>to Marshall CT score</td>
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<tr>
<td>4.</td>
<td>Higher inter-rater reliability</td>
<td>Comparatively less inter-rater reliability</td>
</tr>
<tr>
<td>5.</td>
<td>Uncertain predictive</td>
<td>Better predictive</td>
</tr>
<tr>
<td></td>
<td>value in patients requiring decompressive craniectomy</td>
<td>value in patients requiring decompressive craniectomy</td>
</tr>
<tr>
<td>6.</td>
<td>Individual parameter of</td>
<td>No such restriction on</td>
</tr>
<tr>
<td></td>
<td>mass lesion evacuated/non</td>
<td>individual parameters</td>
</tr>
<tr>
<td></td>
<td>evacuated is retrospective</td>
<td>measured</td>
</tr>
<tr>
<td></td>
<td>and hence has variable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>application</td>
<td></td>
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<tr>
<td>7.</td>
<td>Patients with lower GCS</td>
<td>Prognosis can be discriminated even in</td>
</tr>
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<td></td>
<td>are likely to have grade IV or V and hence no significant discriminatory predictive value in these cases</td>
<td>patients with low GCS based on individual CT characteristics</td>
</tr>
<tr>
<td>8.</td>
<td>Not ordinal</td>
<td>Ordinal</td>
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</table>

Abbreviations: CT, computed tomography; GCS, Glasgow coma scale.

Predictive Value of Rotterdam CT Scoring System
Mohammadifard et al conducted a comparative study of Marshall and Rotterdam scoring system in predicting early deaths after brain trauma in a cohort of 150 patients. Mean age was 43.36 ± 21.65 years, mean GCS was 8.7 ± 3, and mean Marshall and Rotterdam CT score was 3.2 ± 1.3 and 2.5 ± 1.0, respectively, in this study. They found a significant correlation between the Rotterdam score and mortality at 2 weeks, 1 month, and after 3 months; however, no such correlation was found with Marshall score. Sensitivity and specificity for mortality prediction at 2 weeks for Rotterdam and Marshall score were 56, 94.11%, and 87.34, 52.63%, respectively, and 57.69, 94.44%, and 87.34, 52.63%, at 1 month, respectively. Sensitivity and specificity for mortality prediction at 2 weeks for Rotterdam and Marshall score were 57.69, 94.44%, and 87.17, 50%, respectively. Receiver operating characteristic (ROC) area under the curve (AUC) showed higher accuracy in predicting mortality at 2 weeks, 1 month, and 3 months for Rotterdam score as compared with the Marshall score. Huang et al evaluated the efficacy of Rotterdam scoring in predicting outcome and mortality after decompressive craniectomy (DC) in TBI. They reported that Rotterdam score is an independent predictor of unfavorable outcome defined by GOS of 1 to 3, with odds ratio of 1.830, 95% confidence interval of 1.043 to 3.212, and p = 0.035. The study by Huang et al highlights an important limitation of Marshall scoring and utility of Rotterdam scoring in prognosticating TBI patients requiring DC. In the study by Huang et al, 90% of patients requiring DC belong
<table>
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<tr>
<th>S. No.</th>
<th>Authors</th>
<th>Title of the study</th>
<th>Journal published</th>
<th>Year of publication</th>
<th>Country</th>
<th>Participants</th>
<th>Study design and methodology</th>
<th>Conclusions</th>
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<tbody>
<tr>
<td>1.</td>
<td>Bobinski et al17</td>
<td>Dynamics of brain tissue changes induced by traumatic brain injury assessed with the Marshall, Morris-Marshall, and the Rotterdam classifications and its impact on outcome in a prostacyclin placebo-controlled study</td>
<td>Acta Neurochirurgica</td>
<td>2012</td>
<td>Sweden</td>
<td>N = 48</td>
<td>A randomized controlled trial. Included closed TBI patients 15–70 years, GCS &lt; 8 at time of sedation and/or intubation. Pregnant patients and patients with CPP &lt; 10 mm Hg were excluded</td>
<td>A significant correlation between the Marshall and Rotterdam CT scoring. Rotterdam score showed a significant correlation with the predicted outcome as GOS at 3 and 6 months while Marshall score did not correlate</td>
</tr>
<tr>
<td>2.</td>
<td>Charry et al 18</td>
<td>Outcomes of traumatic brain injury: the prognostic accuracy of various scores and models</td>
<td>Neurol Neurochir Pol</td>
<td>2019</td>
<td>Colombia</td>
<td>N = 309</td>
<td>Prognostic discrimination and prediction of mortality and unfavorable outcomes of moderate and severe TBI at 6 months by Rotterdam and Marshall CT score</td>
<td>Similar accuracy of Rotterdam and Marshall CT score</td>
</tr>
<tr>
<td>3.</td>
<td>Deepika et al12</td>
<td>Comparison of predictability of Marshall and Rotterdam CT scan scoring system in determining early mortality after traumatic brain injury</td>
<td>Acta Neurochirurgica</td>
<td>2015</td>
<td>India</td>
<td>N = 134</td>
<td>Prospective, GCS 3–12, follow-up for 2 weeks for early mortality</td>
<td>AUC 0.7.7 for Marshall and 0.681 for Rotterdam score. Good correlation between the predictive value of Marshall and Rotterdam score</td>
</tr>
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<td>4.</td>
<td>Frodsham et al19</td>
<td>Day-of-injury computed tomography and longitudinal rehabilitation outcomes: a comparison of the Marshall and Rotterdam computed tomography scoring methods</td>
<td>Am J Phys Med Rehabil</td>
<td>2020</td>
<td>USA</td>
<td>N = 88</td>
<td>Observational cohort design with a consecutive sample of long-term rehabilitative outcomes prediction of moderate to severe TBI by Marshall and Rotterdam score</td>
<td>None of the scores predicted the Functional Independence Measure motor or cognitive score at discharge or 9 months' follow-up</td>
</tr>
<tr>
<td>5.</td>
<td>Huang et al20</td>
<td>Rotterdam computed tomography score as a prognosticator in head-injured patients undergoing decompressive craniectomy</td>
<td>Neurosurgery</td>
<td>2012</td>
<td>Taiwan</td>
<td>N = 127</td>
<td>A retrospective study of TBI patients who underwent decompressive craniectomy for a mass lesion or malignant cerebral edema. Rotterdam CT scoring and outcome assessed by GOS</td>
<td>Correlation between higher Rotterdam CT scores and poor prognosis. Rotterdam CT scoring is a better prognostic model and more discriminative than the Marshall CT score in prognosticating TBI patients requiring DC</td>
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</table>
correlation with the predicted outcome as GOS at 3 and 6 months while Marshall score did not correlate showed a significant between the Marshall and Rotterdam CT scoring. Rotterdam score A significant correlation

Charry et al

N

p

< 10 mm Hg were excluded = 48 A randomized con-trolled trial. Included closed TBI patients 15–70 years, GCS < 8 at time of sedation and/or intubation. Pregnant patients and patients with CP

S. No. Authors Title of the study Journal published Year of publication Country Participants Study design and methodology Conclusions

1. Bobinski et al17 Dynamics of brain tissue classifications and its impact changes induced by trau-matic brain injury assessed with the Marshall, Morris-Marshall, and the Rotterdam

2. Deepika et al Neurol Neurochir Pol 2019 Colombia N = 309 Prognostic discrimination and prediction of mortality and unfa-vorable outcomes of moderate and severe TBI at 6 months by Rotterdam and Marshall CT score

3. Frodsham et al Am J Phys Med Rehabil 2020 USA N = 88 Observational cohort design with a consecutive sample of long-term rehabilitative outcomes prediction of moderate to severe TBI by Marshall and Rotterdam score

Correlation between higher Rotterdam CT scores and poor progno-sis. Rotterdam CT scoring is a better prognostic model and more discrim-inative than the Marshall score in prognosticating TBI patients requiring DC

20 Rotterdam computed tomography score as a prognosticator in head-in-jured patients undergoing decompressive craniectomy

Continued

7. Maas et al Prediction of outcome in traumatic brain injury with computed tomographic characteristics: a compari-son between the computed tomographic classifica-tion and combinations of computed tomographic predictors

Neurosurgery 2005 Rotterdam, Netherlands N = 2,249 Patients of inter-national and North American tirilazad trials between 16 and 65 years with GCS 3–12 closed TBI. Created Rotterdam classification

Significant CT predictors of mortality were midline shift, basal cistems, intraventricular blood, and traumatic SAH. The discriminatory analysis showed AUC 0.705, considerably higher than the Marshall scoring

8. Majdan et al Outcome prediction after traumatic brain injury: com-parison of the performance of routinely used severity scores and multivariable prognostic models

J Neurosci Rural Pract 2017 Austria N = 866 Retrospective Rotterdam and Marshall CT score had similar pre-dictive value as per ROC curve AUC

9. Mata-Mbemba et al Early CT findings to predict early death in patients with traumatic brain injury: Marshall and Rotterdam CT scoring systems compared in the major academic tertiary care hospital in northeastern Japan

Academic Radiology 2014 Japan N = 245 Retrospective, age > 15 years, TBI and CT within 24 hours, all GCS

Higher Marshall and Rotterdam scoring had higher mortality and both the scoring systems had similar discrimina-tory power as per AUC characteristics (0.85 for both)

10. Mohammadifard et al Marshall and Rotterdam computed tomography scores in predicting early deaths after brain trauma

Eur J Transl Myol 2018 Iran N = 150 Descriptive analytical study of patients > 18 years of age with TBI within 24 hours and GCS ≤13 with an abnormal CT scan

Rotterdam CT scoring system has better accu-racy as per AUC ROC at 2 weeks, 1 month, and 3 months than Marshall scoring

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<th>S. No.</th>
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<th>Journal published</th>
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<td>11.</td>
<td>Munakomi et al.</td>
<td>Role of computed tomography scores and findings to predict early death in patients with traumatic brain injury: a reappraisal in a major tertiary care hospital in Nepal</td>
<td>Surg Neurol Int</td>
<td>2016.</td>
<td>Nepal</td>
<td>N = 364</td>
<td>A prospective study of consecutive TBI patients. All GCS included. AUC ROC measured for each CT scoring</td>
<td>Higher Rotterdam score has higher mortality but mortality prediction of score 5 was lesser than 4 or 6 with AUC of 0.912 for Marshall and 0.929 for Rotterdam scoring</td>
</tr>
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<td>12.</td>
<td>Pargaonkar et al.</td>
<td>Comparative study of computed tomographic scoring systems and predictors of early mortality in severe traumatic brain injury</td>
<td>Journal of Clinical Neuroscience</td>
<td>2019</td>
<td>India</td>
<td>N = 157</td>
<td>A prospective observational study, clinical outcome by GOS and prediction by Rotterdam and Marshall CT scoring. Severe TBI adult patients between 8 and 65 years. Polytrauma patients were excluded</td>
<td>ROC analysis showed AUC, 0.742 for Marshall and 0.751 for Rotterdam CT scoring system</td>
</tr>
<tr>
<td>13.</td>
<td>Raj et al.</td>
<td>Predicting outcome in traumatic brain injury: development of a novel computerized tomography classification system (Helsinki computerized tomography score)</td>
<td>Neurosurgery</td>
<td>2014</td>
<td>Finland</td>
<td>N = 869</td>
<td>Open cohort retrospective single-center study</td>
<td>Rotterdam has better discrimination with AUC of Marshall 0.63, and Rotterdam CT score 0.70</td>
</tr>
<tr>
<td>14.</td>
<td>Waqas et al.</td>
<td>Predicting outcomes of decompressive craniectomy: use of Rotterdam computed tomography classification and Marshall classification</td>
<td>British Journal of Neurosurgery</td>
<td>2016</td>
<td>Pakistan</td>
<td>N = 197</td>
<td>A retrospective observational cohort of TBI patients requiring DC</td>
<td>AUC for Rotterdam score 0.687 for mortality and 0.666 for an unfavorable outcome. Rotterdam CT score &gt; 3 independent predicted mortality and unfavorable outcome for TBI patients requiring DC</td>
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</table>

Abbreviations: AUC, area under the curve; CT, computed tomography; DC, decompressive craniectomy; GCS, Glasgow Coma Scale; GOS, Glasgow Outcome Scale; ROC, receiver operating characteristic; TBI, traumatic brain injury.
to Marshall class V. In a similar study, Waqas et al found that Rotterdam score has significant independent predictive value for mortality and unfavorable outcome in TBI patients requiring DC. Therefore, in these patients, Rotterdam CT scoring would have more discriminatory predictive strength. Mass et al reported in their study on the efficacy of Marshall CT scoring system, that combination of individual CT findings, additional CT findings like the presence of traumatic SAH, and detailed description of mass lesions predicts outcome better than the Marshall CT scoring system. In fact, Marshall classification was not intended to be a prognostic model and thus Mass et al compared it with a model comprising of individual CT characteristic findings and reported Rotterdam score to be a better prognostic model. In the observational study by Pargaonkar et al, researchers found that Rotterdam score had a better linear relationship between scoring and mortality than Marshall CT score. Similar findings were obtained in the study by Munakomi et al. Also, the positive predictive value for predicting mortality was higher for Rotterdam scoring (82.5%) as compared with the Marshall CT scoring system (79.3%). Similar results were reported with the highest accuracy for Rotterdam CT score in predicting the outcome based on GOS at 3 and 6 months (AUC 0.722) as compared with the Marshall score (AUC 0.657). Nelson et al reported better predictive power of CT characteristics of Rotterdam score than Marshall score in extended analysis of CT scans. They further suggested that the most important parameter in predicting mortality is the magnitude of midline shift which is a continuous variable.

Limitations of the Rotterdam CT Scoring System
One of the drawbacks of the Rotterdam scoring is that the authors used CT scan performed within first 4 hours of the admission and not the worst CT scan, as worst CT scan is done later which might have better predictive power. Another limitation is that patients with mild head injury were excluded from the study by Mass et al and hence Rotterdam CT scoring might not be applied to the prediction in these patients who can have neurological deterioration over time. Since midline shift and status of the basal cisterns are important CT characteristics in Rotterdam score, the inter-rater variability is a concern when a CT scan is evaluated by physicians with different expertise. Studies reported higher interclass correlation for Marshall scoring as compared with the Rotterdam scoring. The classification fails to predict long-term rehabilitation of TBI patients and clinical outcomes in penetrating TBI patients.

Limitations of the Marshall CT Scoring System
The problem with Marshall scoring is that it is more descriptive than discriminatory as most of the patients who would require DC belong to Marshall class IV or V and therefore it is not possible to use it as a predictor for mortality in these cases accurately. Marshall CT score is based on data collected between 1984 and 1987 from 753 patients of Traumatic Coma Data Bank, which is much less than the number of patients in the study for the Rotterdam score. The predictor of hematoma evacuated or nonevacuated can only be applied retrospectively. The cutoff of 25 mL is not uniform for the traumatic intracranial lesions as guidelines differ for different pathology. It is expected for the mortality in patients with Marshall grade V to be lesser than grade IV and V as it includes evacuated mass lesions. Also, in any study patients with Marshall score IV are likely to be less in number as many patients with midline shift may require surgery irrespective of GCS and this practice varies among the surgeons and centers. The study by Bobinski et al showed that 17 patients had evacuated mass lesions at 24-hour CT who had nonevacuated mass lesion at the initial CT scan. This highlights one very important scenario where prognostication based on Marshall score should be performed with care as the score and predicted outcome can change over time. They further reported that Rotterdam score bears significant negative correlation with GOS based on initial and 24-hour CT scan, but for Marshall score, negative correlation with GOS was found based on initial CT scan and not on CT scan done at 24 hours. Similar to Rotterdam classification, the classification fails to predict long-term rehabilitation of TBI patients and clinical outcomes in penetrating TBI patients. Marshall CT scoring is not appropriate as prognostic model for TBI patients requiring DC.

Rotterdam and Marshall Scoring in Pediatric TBI Patients
Marshall and Rotterdam CT scoring has not been validated in patients aged <14 years. Rotterdam scoring is used to predict unfavorable outcome in pediatric populations, results were different from the adult population. Pediatric population had better outcomes for the same scoring in less severe injuries but worse outcomes in cases of more severe injuries for the same scoring in adults. All the patients with Rotterdam score of 6 had GCS 3 and 22% of the patients with Rotterdam score of 2, that is, normal scans, had GCS of 3.
As a result, they suggested modification in Rotterdam score for better accuracy in the pediatric age group as predicted mortality = \[ \frac{e^{-6.57} + (1.527 \times \text{Rotterdam})}{1 + e^{-6.57} + (1.527 \times \text{Rotterdam})} \]. Higher mortality (odds ratio 1.75) was found to be associated with higher Rotterdam score in a prospective observational cohort of 92 pediatric patients with age range of 1 month to 6 years suggesting that Rotterdam score can be used to predict mortality in pediatric patients.10 Contrary to this, Mikkonen et al40 reported that adult CT scoring system performs well in a retrospective cohort of 341 TBI patients aged < 18 years treated in the intensive care unit, with Rotterdam score having better predictive value (AUC 0.80) than Marshall score. Talari et al41 reported in a retrospective cohort of 506 pediatric patients of the suitability of Rotterdam score cutoff of 3 for predicting early mortality and clinical outcome with acceptable sensitivity and specificity. ROC AUC to delineate the strength in predicting survival in pediatric patients was 0.838 and 0.781 and for GOS ≤ 3 was 0.748 and 0.663 for Rotterdam and Marshall CT score.42 Similar results were found for the Rotterdam score in other studies.43

**Conclusion**

A combination of clinical parameters, severity, ischemic and hemodynamic parameters, and CT scoring system could predict the prognosis of TBI patients with significant accuracy. Marshall scoring is more descriptive, widely accepted with good predictive value, and good inter-rater reliability, and Rotterdam score is superior in the description of dynamics of intracranial changes. Though most of the studies concluded that Rotterdam CT scoring is better than the Marshall CT scoring, we believe that the two scoring systems are complimentary. As either of the scoring systems has its limitations and Rotterdam CT scoring system improves upon Marshall CT scoring, a combination approach would yield a better predictive model. The predictive power of Rotterdam score is different in the pediatric age group as compared with adults and modifications are required for better applicability of CT-based scoring system in the pediatric age group. Further prospective comparative studies in mild TBI patients, pediatric, and geriatric TBI patients are required to establish their wider applicability.

**Conflict of Interest**

None declared.

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