Case Report

An unusual recovery from traumatic brain injury in a young man

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Context: Traumatic brain injury (TBI), a complex neurological traumatic incident where brain function is disrupted due to physical trauma, can be categorized in multiple ways and is commonly scored using the Glasgow Coma Scale. Severe closed head injury is a form of TBI with a Glasgow Coma Scale less than 8. The outcomes and prognosis are not uniform in the population but mortality is estimated at 30–50 percent. In this case of severe closed head injury, the patient was able to make a near full recovery after several neurosurgery and medical treatments and intercessory prayer to Saint Luigi Guanella.

Findings: A 21-year-old male patient received a severe closed head TBI and bilateral hemotympanum while rollerblading without a helmet. After imaging, a left frontal craniotomy and evacuation of epidural and subdural hematomas and resection of a left frontal contusion were performed. Intracranial pressure increased and the patient experienced a transtentorial herniation. He underwent a right frontotemporal and subtemporal craniectomy and evacuation of a frontotemporal subdural hematoma. The patient had intraventricular hemorrhage to which a ventriculostomy was performed and later converted to a ventriculo-peritoneal shunt for recurrent hydrocephalus. The patient was not expected to regain consciousness, but made a recovery after 24 days in the hospital and 10 days in rehabilitation. The patient followed up 6 months after injury for a cranioplasty and soon after returned to near baseline.

Conclusions/clinical relevance: In this extraordinary case, the severe closed head injury the patient sustained required intensive neurosurgical and medical treatment and the prognosis for recovery of consciousness was very poor; however, with treatment and rehabilitation and intercessory prayer to Saint Luigi Guanella, this patient was able to recover close to baseline from a Glasgow Coma Scale of 7.

Lay Summary: Head injuries vary in severity and traumatic brain injuries can be extremely serious leading to bleeding, loss of consciousness, and can affect verbal responses, muscles movement in motor responses, and responses with eye movement. Traumatic brain injuries require medical care to assess the severity and treat the injury. In this case report, we discuss a patient's very severe closed head injury while rollerblading without a helmet from which he was not expected to make a full recovery, but did so following intensive medical treatment, rehabilitation, and intercessory prayer to Saint Don Guanella to combat the initial injury and subsequent issues.

Keywords: Traumatic brain injury, closed head injury, coma, Glasgow Coma Scale, cerebral contusion, Saint Luigi Guanella

CASE REPORT

On March 15, 2002, a 21-year-old man with a past medical history of osteomyelitis at age 12 was rollerblading backwards with his friend on Baltimore Pike in Springfield, PA. The friend asked him to slow down but the patient went faster and hit a pothole in the road. The friend said he flew up 8 and 10–15 feet over and came down straight on the back of his head. He was not wearing a helmet. He immediately lost consciousness and sustained a seizure. He regained consciousness before the ambulance came, but then lost consciousness. When the police arrived they noted he was breathing, unresponsive, and bleeding profusely. He was transported to the emergency room at Crozer Chester Medical Center at the highest level of trauma injury (trauma activation). On arrival, his Glasgow Coma Scale (GCS) was 7 displaying some movement of the extremities but no conscious behavior. GCS rating of 8 or below is considered a severe closed head injury. He had bilateral hemotympanum—blood behind the ear drums. He was intubated and treated with mannitol, vecuronium, and midazolam. Atropine was given for bradycardia. A computed tomographic (CT) scan showed severe left frontal contusion with an epidural hematoma, a left parietal subdural hematoma, a right frontal contusion and right temporal contusion, extensive traumatic subarachnoid hemorrhage, left-sided mass effect with shift of the midline structures to the right, and a basilar skull fracture extending through the right occipital bone. An abdominal CT scan showed no evidence of major intra-abdominal injury and small bilateral pleural effusions. A CT scan of the cervical spine showed no evidence of cervical spine fracture. An elevated international normalized ratio (INR) of 1.4 was noted and the patient was given fresh frozen plasma and he also received Dilantin.

The patient underwent an emergent left frontal craniotomy with evacuation of epidural and subdural hematomas with resection of the left frontal contusion, including approximately one-third of the left frontal lobe, which was actively bleeding. An intracranial pressure (ICP) monitor was placed. The bone flap was left off and the brain was covered with Duraguard. A drain was placed underneath the dura mater and tunneled out separately under the skin. Prior to closure, the dura was tacked up to the cranium with epidural sutures. ICPs, normally 7–15 mmHg, were initially 10–19 mmHg but later rose to 20–26 mmHg. A repeat CT scan showed status post left frontal craniotomy with bulging of the left frontal lobe through the defect. Extensive bleeds were then noted on the right side including the right subdural or epidural space within the right brain parenchyma in the frontal lobe. A marked increase of ICP not only produced the above bulging of the cortex, but caused marginal transtentorial herniation. He underwent a right frontotemporal craniotomy, subtemporal craniectomy, and evacuation of the frontotemporal subdural hematoma. A subdural drain was placed. ICP reduced to 12–14 mmHg. He was noted to have an infiltrative process at the right lung base and was treated with antibiotics.

The family was informed that the patient had only a 20 percent chance of survival and, if he survived, he would most likely be in a persistent state of unconsciousness. Chances for full recovery were held to be non-existent. On March 19th, the feast of St. Joseph, a friend of the family who worked at Don Guanella School brought two relics¹ of Don Guanella to the family, one of which the mother kept and the other was pinned to the patient's hospital ID bracelet. The friend, the family and the residents, priests, and staff at Don Guanella Village/

Cardinal Krol Center prayed for Don Guanella's intercession for the recovery of the patient.

Five days after the injury, an inferior vena cava (IVC) filter was placed to prevent a pulmonary emboli. A head CT scan showed severe bilateral frontal parenchymal hemorrhage status post bilateral craniectomy with a large amount of brain swelling. There was intraventricular hemorrhage with mild dilation of the temporal horns. A ventriculostomy was performed seven days after the injury because of persistently elevated ICP and enlargement of the ventricles seen on CT scan. A tracheostomy and gastrostomy were placed the same day in preparation for long-term care. The ventriculostomy was converted to a ventriculo-peritoneal shunt on the thirteenth day for hydrocephalus when the ventriculostomy was clamped.

Four days after the injury, the patient was noted to respond to painful stimuli in both legs—though the right leg was weaker than the left. On trauma rounds on the fifth day, he was noted to have a GCS rating of 7. The patient was sedated and intubated through nine days after the injury. On the ninth day, the patient began to open his eyes and follow commands. His GCS rating improved to 10 and was noted to be starting to "lighten" and wake up. On the eleventh day, when the patient was noted to be starting to wake up, more active and agitated at times, the GCS was 10–11. Weaning off the respirator began. On the twelfth day, he began to follow simple commands. By the thirteenth day, he was awake and responsive, moving all extremities with good strength, nodding his head, giving thumbs up, and shrugging his shoulders to communicate, though restless and picking at his tubes. He was extubated and placed on 40 percent oxygen via the trach collar. By the fourteenth day, he was able to follow simple commands and maintain

attention for a task for 10–15 minutes during physical therapy. At occupational therapy, he was able to tolerate a 30-minute session with minimal/moderate checks with participation in a simple task. Sixteen days after the injury, neurology noted he was much sharper, awake, and alert and oriented $\times 2$. He began speech therapy on the seventeenth day and was noted to demonstrate reading comprehension for individual words. By twenty days, the patient was able to ambulate 100 feet. The tracheostomy was removed by twenty-two days, and he was transferred to Bryn Mawr Rehabilitation twenty-four days after the injury. During his stay he was also evaluated for dysphagia, and initial swallowing studies showed some aspiration; however, this improved and he was started on a liquid diet. During rehabilitation the patient had difficulty with numbness in the foot and had to learn to walk again, but progressed remarkably rapidly. His memory came back within a month. He was in the rehabilitation hospital for ten days and was discharged home, with continued outpatient therapy at home.

The patient returned to the hospital 6 months later for a cranioplasty to repair the severe cranial defects from the craniotomies performed. On admission, he was noted to be neurologically intact with evaluation of high and integrated function well within normal limits. During surgery, he had two seizures but these were controlled and he otherwise did well. After discharge, he experienced another seizure which required the addition of Keppra to his Dilantin. By Christmas of 2002, he felt completely normal and back to baseline. He later developed a possible Bells' palsy, noted to have a positive Lyme titer, and was treated with oral antibiotics and resolved.

Psychometric evaluation was performed on February 28, 2005, by Phillip

J. Miraglia, Ph.D., ABPP. The assessment follows.

William's performance on the WAIS-III, Bender Gestalt, Memory for Designs and Hooper Visual Organization test are not in themselves suggestive of brain dysfunction and are far superior to what would be expected on the basis of the reports of his injury. Only one index score on the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS) (Delayed Memory) is within the Borderline Range. The other Index Scores are in the Average or, more often, the Low Average Range. While relatively weak functioning on the Delayed Memory Index Scale is consistent with closed head trauma, Williams's score is significantly higher than would be expected given the reported severity of his injury.

In my judgment, William's overall performance on these psychometric measures is significantly higher and more consistent than I would have expected given the nature and extent of his reported brain injury.

Patrick O. Elliott D.O., the admitting trauma surgeon, noted:

to think that this guy came back to baseline would be extraordinary because it's like a major stroke. It's both sides of the brain. ... complete recovery from this injury is felt to be unlikely, if not impossible.

Richard V. Buonocore, M.D., the neurosurgeon noted,

Eventually, after exhausting all modalities, both medically and surgically, the patient's intracranial swelling gradually subsided. Again, it was explained to the family that the patient probably would not recover from a coma due to the extensive and severe brain injury. Remarkably, the patient gradually continued to improve and slowly became responsive, alert, appropriate, and was able to follow commands. ... Eventually

the patient regained almost a complete recovery, both clinically and neurologically. His recovery and the extent of his recovery went well beyond medical expectations.

CLINICAL ASPECTS OF TRAUMATIC BRAIN INJURY

Demographic/Incidence

Traumatic brain injury (TBI) is a complex neurological traumatic incident in which the normal function of the brain is disrupted due to a physical trauma to the head. Out of the roughly 1.7 million people who experience a TBI annually, 52,000 die, 275,000 are hospitalized, and 1,365 million are treated for their injury. Males experience a TBI more frequently than females. The highest rate of emergency department visits are from children 0 to 14 years of age who have experienced a TBI with a total of 473,947 annually; however, the most hospitalizations and deaths occur in adults 75 years and older with TBIs. The main causes of TBIs are falls, motor vehicle accidents, assault, and being struck by/against an object (Faul et al. 2010).

Falls seem to cause the majority of TBIs in children of 0–14 years old and adults older than 65; however, they can occur in adults younger than 60 years of age. Environmental and occupational factors play a role in the severity of the TBI. Numerous studies have been done of work-related falls and a few of non-work-related falls. In those studies, the distance to the ground effects the severity of the TBI—whether off a structure to the ground, from the stairs, or at ground level. Of the work-related TBIs in people under 60 years of age, less than 50 percent of employees returned to their work within 1 year. This statistic along

with the increasing data of falls in the elderly has pushed forward a public health intervention and education to increase the use of helmets by cyclists and in companies where head protection is crucial. It has fostered more techniques and prevention strategies for the elderly and increased care of children around the house to reduce the amount of falls. Alcohol consumption, use or abuse, has also known to be a contributing factor to falls in adults (Friedland, Brunton, and Potts 2013). With falls being the leading cause of TBIs, 35.2 percent annually, more education and prevention needs to be focused on to reduce the occurrence of TBI (Faul et al. 2010).

Motor vehicle accidents and traffic-related accidents are another main cause of TBI and the leading cause of death in TBI patients with 31.8 percent (Faul et al. 2010). These accidents most severely affect pedestrians, cyclists, and motorcyclists. Drivers and passengers equally sustain TBIs. The average age of those experiencing TBI is between 20 and 44 years old and males are more frequently affected than females (Majdan et al. 2012). Alcohol consumption is again an important cause of accidents resulting in TBIs. Throughout the world, the leading cause of TBI is either from falls or from traffic-related motor vehicle accidents and this varies depending on country. Motor vehicle and traffic-related accidents, regardless of rank, still represent one of the main reasons for TBI that result in mortality and disability (Tagliaferri et al. 2006).

Another main cause of TBI is blast injury in the military. During deployment, with the use of combat explosives, blast injuries lead to mild TBIs and result in significant post traumatic stress disorder. Compared with other injuries, soldiers who experienced loss of consciousness and altered mental status more closely related

their symptoms to blast injuries (Hoge et al. 2008). The recent increase in blast injuries can be correlated to the steady increase in TBI in the military from combat weapons like improvised explosive devices. While the protective gear of the military shield many of the vital organs, the equipment cannot protect against the sudden explosion and blast wave effect on the soldiers brain, which can result TBIs (CEMM 2013).

Presentation/Evaluation

With a wide range in the population and various causes, it is important to be able to evaluate and categorize TBIs. There are several ways in which TBIs can be classified based on their injuries. They can be separated by the effect the injury has on the brain. Primary injuries are those in which at the traumatic incident or impact, the brain experiences parenchymal damage. Secondary injuries, on the other hand, occur at a time after the traumatic event and are the focus of neurosurgical care of TBI. The goals include providing adequate oxygenation to the brain and avoiding seizures, hypoxia, hyponatremia, hypercarbia, and hypertension (Tsao 2012). TBIs are also commonly classified by their mechanism of injury commonly known as penetrating or open head injuries and blunt or closed head injuries. These types of injuries are separated by what the brain is experiencing at impact or after impact either through a fall, motor vehicle accident, a blast injury, or any mechanism to cause a TBI. Through observations of TBIs, research has employed experimental systems designed to resemble the different types of injuries. Open head injuries can be mimicked experimentally by fluid percussion in which fluid enters the dura matter resulting in vascular damage and subarachnoid

or petechial hemorrhage. These injuries can also be studied by controlled cortical impact in which tissue deformation the dura mater produces edema and increased ICP. Closed head injury can be mimicked experimentally by either impact or non-impact models. Impact closed head injury occurs when a force is dropped on the skull but does not produce a skull fracture. Non-impact closed head injuries include rapid rotational forces and waves like those seen in military blast induced TBIs (Namjoshi et al. 2013).

Although these two classifications help us to identify the different presentations of the injury, they do not provide enough information into the severity of the TBI and the state of the patient for the appropriate intervention and treatment. The GCS is used to grade a patient's TBI severity. The GCS focuses on the three parameters of eye, verbal, and motor responses. The eye responses are ranked into four groups: 1 is no eye opening, 2 is eye opening to pain, 3 is eye opening to verbal command, and 4 is eye opening spontaneously. The verbal responses are ranked into five groups: 1 is no verbal response, 2 is incomprehensible sounds, 3 is inappropriate words, 4 is confusion, and 5 is orientation. The motor response is ranked into six groups: 1 is no motor response, 2 is extension to pain, 3 is flexion to pain, 4 is withdrawal from pain, 5 is localized pain, and 6 is ability to obey commands. The sum of the patient's scores in each of the three parameters will result in the patient's GCS. The GCS rank the severity of TBI into three groups. Patients with a mild TBI have a GCS of 13–15. Patients with a moderate TBI have a GCS of 9–12. Patients with a severe TBI have a GCS of 3–8 (Teasdale and Jennett 1974).

While this scale provides a great deal of information regarding the severity of injury, within each parameter, the patients

can differ considerably on their form of injury. It is crucial that imaging is used to illustrate the morphological and pathological issues to determine the appropriate treatment of the TBI. A CT scan without contrast is recommended in patients with a severe and moderate TBI as indicated by a GCS of 12 and lower. It can be used in patients with a GCS greater than 12 if they meet the New Orleans Criteria or the Canadian CT Head Rule where the patient is either greater than 60 years of age, has persistent neurologic deficits, experiences headaches or vomiting, has amnesia prior to trauma for more than half an hour, has a loss of consciousness greater than 5 minutes, has a depressed skull fracture, is intoxicated with drugs or alcohol, or is experiencing seizures. The CT scan is very accessible and able to identify signs of herniation and mass effects from the head injury. There are several other commonly used imaging modalities to understand TBIs. A CT angiogram allows assessment of vascular injury that may have occurred at the time of or post-injury. A dynamic perfusion CT provides a beneficial prognostic prediction based on the analysis of brain perfusion. The practical disadvantage of CT is the radiation exposure to the patient. Magnetic resonance imaging (MRI) is favored when the findings are inconclusive in a CT or better delineation of the brain is required. The MRI provides a visualization of the brain in detail including the cortical and subcortical junction or white and gray matter, rapid identification of strokes, and ability to identify shear injury. These types of imaging help to identify the pathological findings and results from the trauma while predicting the patient's prognosis (Tsao 2012).

Due to the variety of classifications of TBI, there is a push to have a new classification which incorporates the

pathophysiology of the injury with the acute clinical assessment, neuro-radiologic assessment, biomarkers, and functional outcomes assessment. The acute clinical assessment would need to continue to use the GCS while incorporating more clinical findings to differentiate and provide information of the moderate and mild TBIs. More specifically tailored monitoring post-injury would need to occur and age-appropriate techniques for care of TBI would need to be developed to standardize the assessment. Current imaging is beneficial to correlate clinical presentation with anatomic changes in the brain. As further refinements are made in MRI better classification and prognostic information will be available to guide treatment. The biomarkers classification may have a role in the classification and treatment of TBI. The functional outcome assessment would need to be standardized and accessible without restriction to patients and hospitals. This type of data would allow the differentiation within severe TBIs and focus treatment based on age (Saatman et al. 2008).

Pathophysiology/Treatment

These classification systems provide valuable insight into the patients underlying condition and imaging aids in assessing the damage; however, it is through assessment and interpretation of the patient, injury site, and imaging that allow physicians to focus treatment based on the TBI. Injury care can be broken into primary and secondary injuries. Primary injuries occur at the moment of trauma and impact. These cause shearing, compression, disruption of membranes, and axonal injury through fractures, hematomas, hemorrhage, and edema. Secondary injuries occur from cellular damage from the initial impact and trauma. These are

often avoidable or preventable and can occur within hours to days after the incident. Secondary injuries involved intracerebral pressure, inflammation, ischemia and reperfusion injury, shift, accumulation of excitotoxins, free radical formation, and apoptosis (Tsao 2012).

At the time of impact, several types of primary injuries can occur. Skull fractures are described as open when the skin is opened and the bone exposed or closed where the skin integrity is preserved. When the skull is significantly depressed resulting in dural tears this increases the risk of parenchymal injury. Intracranial hemorrhages can result from fractures. Most synonymously, the epidural hematoma is associated with temporal bone fracture that interrupts the middle meningeal artery and causes bleeding between the dura mater and the skull. Subdural hematomas occur due to lacerations and disruption of the bridging veins or from severe parenchymal injury. Both of these types of hematomas cause compressions forcing the brain away from the skull resulting in shift and an increase in intracerebral pressure. Intracerebral hematomas affect the frontal and temporal lobes and can display a secondary hemorrhage and contusion. Subarachnoid hemorrhage is a type of hemorrhage that usually does not require neurosurgery but may require cerebrospinal fluid drainage to prevent hydrocephalus and outflow obstruction. Edema can cause an increase in the intracerebral pressure and limit perfusion. The use of mannitol or hypertonic saline in the setting of euolemia is crucial to preventing further edema (Wolf 2013). These can often be due to contusions where the pia mater is torn allowing fluid and blood from the injured brain to enter the subarachnoid space (Moore, Dalley, and Agur 2010). Diffuse axonal injury can occur due to shearing in which the white matter can be damaged. Rapid

changes from acceleration to deceleration at impact can cause stretching of the axonal fibers and myelin sheets that can cause ischemia and neuronal dysfunction. Petechial hemorrhages can be seen on a CT within the white matter as a result (Wolf 2013).

Secondary injury prevention has become a major focus in patients with TBI to prevent elevation in ICP, ischemic-reperfusion injuries and inflammation. One of the main interventions is through continuous oxygen supply. Endotracheal intubation may be difficult in severe craniofacial and TBIs; however, ventilation is crucial and maintenance a PaO_2 of at least 60–70 mmHg is required. Hyperventilation can be instituted acutely in the management of elevated ICP, but is detrimental over sustained periods due to reduction in blood flow. Hemodynamics should be monitored and adjusted accordingly. If the patient is experiencing intracranial hypertension, adequate maintenance and monitoring of the mean arterial pressure and a cerebral perfusion pressure greater than 60 mmHg is recommended (Wolf 2013).

Neurological and neurosurgical care focuses on intracerebral pressure and the avoidance of cerebral herniation. Patients with a GCS of 8 or less should be monitored for intracerebral pressure changes or if they have two of the following: 40 years of age or older, systolic blood pressure of 90 mmHg or less, or have posturing during examination. Management to a pressure of less than 20 mmHg or optimally of 15 mmHg, elevated bed to 30° and maintaining the head in a midline position to allow venous flow from the head. The goal of elevated intracerebral pressure is to decrease the pressure below 20 mmHg. Other techniques for management include early removal and care for hematoma formation, hypertonic saline, or mannitol to control the edema with

hyperosmolar therapy with a sodium goal up to 160 mEq/L, prevention of hyperthermia, and promotion of a slight hypothermia. Induced hypothermia is controversial but research has proven a positive effect of reducing elevated intracerebral pressure. If repeat imaging and therapy do not control or help in the reduction of intracerebral pressure, a decompressive hemicraniectomy can be performed to expand the intracranial space and reduce ICP, which aids in relieving the inflammation and edema to increase social rehabilitation. An extraventricular drain can also be placed to aid in relieving hydrocephalus either acute or obstructive (Tsao 2012; Wolf 2013).

Outcome

There is extensive literature on the outcome after severe closed head injury (GCS 8 or less) and moderate closed head injury (GCS 9–13). The types of injuries are not uniform and predicting outcome is difficult. Mortality after severe closed head injury is estimated at 30–50 percent with most deaths occurring early due to cerebral edema and intracranial hypertension (Sherer, Madison, and Hannay 2000). Within severe closed head injury the mortality varied with severity. Those patients with a GCS of 3 had a mortality of 76 percent and those scoring 6, 7, 8 a mortality of 18 percent. Patients with non-surgical mass lesions had a mortality of 31 percent in contrast to those requiring craniotomy at 39 percent (Marshall et al. 1991). Mortality rates following moderate closed head injury are much lower and estimated under 10 percent. Persistent vegetative state is an uncommon outcome following either severity of injury at less than 10 percent (Sherer, Madison, and Hannay 2000).

For survivors following a severe closed head injury, 32 percent have severe disability at 3 months with slow improvement of the majority to moderate disability at 1 year. Good recovery is the most common outcome for those surviving a severe closed head injury. Twenty percent of all severe closed head injury or 40 percent of all survivors reach a good recovery. Good outcome does not mean recovery back to their baseline prior to the injury. In terms of employment, it is estimated 37 percent of severe closed head injured patients return to work. Regarding independence at 11 percent were independent, 11 percent independent with night supervision, 49 percent with part time supervision, and 26 percent with direct supervision (Sherer, Madison, and Hannay 2000). Survivors of severe closed head injuries live with long-term disabilities that affect employment and independence.

In respect to this case, this young man had two craniectomies. A craniotomy is the surgery where the skull is removed and replaced after evacuating the hematoma. A craniectomy is a surgery where the clot is removed, but the brain swells beyond the cranial margins precluding bone replacement. From the literature, the mortality of his injury should approach 40–70 percent and if the patient survives the likelihood of a good outcome is very small. The recovery described here is extremely atypical and may be called miraculous.

BIOGRAPHY/SPIRITUALITY OF ST. LUIGI GUANELLA

Luigi Guanella, the future saint, was born to Lorenzo and Maria (Bianchi) Guanella on December 19, 1842, in the small Alpine village of Fraciscio near the Splügen Pass and the Swiss border. He was the ninth of thirteen children in this very devout Catholic family and, as with

most families in the St. Giacomo and St. Filippo valley, were primarily shepherds and farmers. His parents were models and teachers of Christian family life with Maria's kind, gentle, and caring nature providing for both the body and soul of the family and Pa Lorenzo, as head of the "domestic church," teaching his children through stories in Sacred Scripture and teaching them of heavenly things.

Three events in the early childhood of Luigi foreshadowed his future vocation as priest and Founder and shaped his life as a saint. After listening to the stories from their father, in front of the fireplace, of Jesus caring for the poor, Luigi and Caterina, his younger sister and closest to him in age, would go outside to prepare soup for the poor using water and dirt. This was an experience often recalled by Fr. Luigi and it was evident in a continual concern for those in need which marked his life. At the age of 6 or 7, a mysterious encounter with an old man left a deep impression on this future priest. He heard the bells of his parish church on the feast of St. John the Baptist, the patronal feast of the parish, and ran to church with the bag of candy he had in his hands. Not wanting to bring the candy into church but also not wanting to lose it, he decided to hide the candy in a wood pile near the church. As he approached the wood pile, he heard someone clapping his hands and it was a little old man holding out his hands as if he was asking for the candy. Luigi ran away from the man, placing the candy inside of his shirt, and, looking back before entering the church, he saw that the old man had disappeared. He recalled later on that

it was at that moment that I felt remorseful in my heart. That act of selfishness is still a weight on my conscience after so many years.

Finally, on the day of his First Communion, at the age of nine, Luigi, feeling great joy, wanted to spend some time in solitude and prayer and so he went to a hill in nearby Gualdera and suddenly heard a voice saying "Louis," "Louis," and he saw the Blessed Mother who revealed to him, in a mysterious way, his future mission. Rarely did he speak of this vision but when he did so he would say that "it was a heavenly vision, a sweet call from above."

At the age of 12, the parish pastor secured for the young Luigi a scholarship to Gallio Academy in Como the seat of the provincial government of what is now the province of Sondrio. This led eventually to Guanella entering the diocesan seminary of Como and being ordained, on May 26, 1866, a priest for that same diocese. On his ordination day, he made a prayer-filled resolution "to be a fiery sword in my holy ministry. I want to be salt of the earth." The zeal represented in this resolution was a driving force throughout his life and it manifested itself, from the very beginning of his priestly ministry, in the sacramental life of the people, catechesis, service to those in need, assisting the families in the communities, and a strong desire to lead souls to the Lord. The flame from this fiery sword also antagonized many government officials in this time of anti-clericalism and also led to some, among the priest of his diocese, to seeing him as "crazy" and one who causes trouble. However, acceptance by others was not the concern of Fr. Guanella but serving the Lord among the people of God, especially those most in need, was his primary motivation. His first assignment was as assistant pastor in the small village of Prosto and then, after a few months, as pastor in the mountain hamlet of Savogno.

Fr. Luigi himself, however, was still not certain if the life of a diocesan priest was the direction that the Lord had planned

for him so, in 1875, he asked for and received permission to join the fledgling community of the future St. John Bosco in Turin. He remained there until 1878 and was called back by his bishop to a parish in Traona. The "fiery sword" of charity in his holy ministry was no less evident in Traona but opposition from government officials, the pastor and some people eventually led to what can be seen as a kind of "exile" to the remote mountain village of Olmo, in August 1881, as pastor of the parish. The few months that he spent in Olmo were a kind of "Calvary" for him but it led to a purification of heart and a deeper resolve to help and serve the poor and in April 1882, he was sent to replace a recently deceased priest in the Lake Como town of Pianello. This proved, in many ways to be the seminal event in the life of Fr. Guanella.

It was in Pianello that Fr. Guanella met a small group of women dedicated to serving the poor and in April 1886, these women, along with Fr. Guanella, traveled on Lake Como to the city of Como to found and establish the "House of Providence" in Como and also to found the religious community of sisters, the Daughters of St. Mary of Providence. The ministry was ever expanding in Como and Fr. Luigi would accept into the house any person in need of help until it became, what he described as, a "Noah's Ark." Having gathered the religious sisters around him, he then founded a community of priests and brothers who would become known as the Servants of Charity. This "Saint of the Poor" and "Samaritan Priest" tirelessly ministered to those in need until that "fiery sword of the holy ministry" was extinguished, with his death, on October 24, 1915. Fr. Luigi Guanella was beatified on October 25, 1964 and canonized on October 23, 2011, and these two dates serve as bookends to his feast day celebrated on October 24th.

Along with the legacy of the Guanellian family of the Daughters of St. Mary of Providence (nearly 700 strong), the Servants of Charity (numbering about 550), the Guanellian Cooperators and the many who are supported and served and who serve in the ministries found in 21 countries today, St. Luigi Guanella also left a rich spiritual patrimony. At the heart of his spirituality is the profound belief that “God is Love” and that he is a loving Father who loves deeply all of his children—unconditionally, infinitely, and generously. From this belief flowed a powerful trust in the Providence of God who provides for and cares for all of his children and who has called each of us to be His “instruments” and “hands” of His loving Providence. Flowing from this precept, Fr. Guanella said that there must always be a preference in caring for those in need to the point that he instructed his sisters, priests, and brothers that they cannot stop until there are no longer people to assist in the world. This “preferential option for the poor” was further strengthened with his conviction that every person, created in God’s image, was a person of dignity—from conception until natural death and in every stage and condition of life. This prophetic “pro-life” vision was fortified by his belief that we are to see the “face of Christ” in those most in need taking his inspiration from the verse of Matthews’s Gospel, “Amen, I say to you, whatever you did for one of these least brothers of mine, you did for me” (Matt 25:40). Recognizing the dignity of all people, persons with developmental disabilities, who were often mocked and mistreated in his day, were called by him the “good children” and his “treasures.” The virtue which undergirded his life was that of charity which for him was to be one’s center of a life of faith and service. Promoting a family spirit was essential to him in which an atmosphere of love, care, acceptance, and fulfilling one’s potential

were its marks. Finally, it was his ardent devotion to the Eucharist which continually nourished, strengthened, and sustained him in his life to the point that he saw the Eucharist as “Our Paradise on Earth.”

This is a short “Portrait of a Saint” and we pray with him “In Omnibus Caritas” (“In all things, charity”—motto of the Servants of Charity) and “In Your Providence is Our Hope” (motto of the Daughters of St. Mary of Providence).

ENDNOTE

1. A relic is a piece of a body of a saint (first-class), an item owned or used by a saint (second class) or an object which has been touched to a first-class relic (third class). More information on Saint Don Guanella is noted below.

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