FOUNDATIONS of Emergency Medicine

Foundations Frameworks

Approach to the Agitated Patient

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Initial Stabilization

1. Attempt verbal de-escalation and determine patient capacity
2. Benzos: midazolam 5-10 mg IV/IM or lorazepam 2 mg IV/IM and repeat
3. Haldol 5 mg IM, also olanzapine (Zyprexa) or ziprasidone (Geodon)- avoid if NMS
4. Ketamine 2-5 mg/kg IM, 1 mg/kg IV
5. Intubate: don't use succinylcholine with risk of rhabdo -> hyperK
6. Once situation is under control, **get a core temp**

Febrile

DDx of Febrile, Agitated Patient

- Non-infectious:
  - Sympathomimetic Toxicity
  - EtOH/Benzo w/d
  - NMS/SS/thyrotoxicosis/environmental
  - ***These patients need benzodiazepines, fluids, cooling***
- Infectious: evaluate and treat for sepsis/encephalitis

Afebrile

Evaluate for underlying medical cause by thinking through DDx for AMS, include all 'febrile' causes as well:

1. Abnormal vitals: hypoxia (air hunger), hypercapnea
2. Tox/Metabolic: sympathomimetic tox, EtOH w/d, thyroid storm, CPK for rhabdo, VBG/lactate, LFTs, etc
3. Structural: ICH, seizure
4. Infectious: encephalitis, sepsis
5. If no medical cause, then the 5th cause of AMS is…

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PSYCH: mania, psychosis -> treat w/ antipsychotics

Excited Delirium Syndrome: Tox + Psych (+medical sometimes) leads to this final common pathway

- Hyperadrenergic state -> hyperthermic, tachycardic, insensitivity to pain, "superhuman strength"
- Risk of sudden/unexplained death, patient often tazed by police, elevated CPK/rhabdo, VBG w/ acidosis