Dealing with combative patients is one of the most difficult challenges an emergency physician encounters. Often brought in against their will, such patients may be agitated, confrontational, and nearly impossible to examine. If not controlled, they may harm themselves or others, including the emergency department staff, other patients, and visitors.

- Rosen’s Textbook of Emergency Medicine

Objectives
- Prevent escalation
- Tips for de-escalation
- Recommendations for meds

Case 1: The Universal Agitated Patient
- 30 y M, unknown hx, “acting crazy!”
Warning Signs

• Angry
• Pacing, changing positions frequently
• Clenched fists or tight grip on rails
• Loud speech
• Previous history
• Sometimes there is no warning

Prevention

• See them fast
• Private but not isolated
• Security nearby
• Keep door open
• You and Pt equidistant to door
• Be disarming
• Safe rooms

De-escalation

• Saves time, money, adverse outcomes, and injuries
• Under-emphasized in ED training
• Act as an advocate.
• Strengthens “therapeutic alliance”
De-escalation: “10 Domains”

- Respect Personal Space
- Do Not Be Provocative
- Establish Verbal Contact
- Be Concise
- Identify Wants and Feelings

- Listen Closely
- Agree or Agree to Disagree
- Lay Down Law and Set Clear Limits
- Offer Choices and Optimism
- Debrief Pt and Staff

Offer Meds Early!

- This is really a stressful situation, would you like a medicine to help?..
- Do you normally take a medicine or is there one you’re supposed to be on?
- What has worked for you in the past?
- What has NOT worked for you?

PO is preferred route

- Offers patient choice and control
- Strengthens therapeutic alliance
- Can be given in elixirs or ODT
- Can even be given to pts in restraints
- Some are quite fast acting
- Generally preferred by patients


Strengthen the therapeutic alliance!
What KIND of medicine should I give a patient with undifferentiated agitation?

**Cast of Characters**

- Lorazepam (Ativan)
- Midazolam (Versed)
- Diazepam (Valium)
- Haloperidol (Haldol)
- Droperidol (Inapsine)
- Diphenhydramine (Benadryl)
- Benztropine (Cogentin)

**ACEP Clinical Policy**

**Level B/C Recommendations**

- Benzo OR a conventional antipsychotic
- If rapid sedation is required, consider droperidol* instead of haloperidol.
- Oral benzodiazepine + oral antipsychotic if cooperative patients.
- HAC may be faster than monotherapy
Expert Consensus Guideline 2005

• “BNZs are recommended when no data are available, when there is no specific treatment (e.g., personality disorder), or when they may have specific benefits (e.g., intoxication).”


Why BZNs are Preferred for Undifferentiated Agitation

• Safe. No EPS. No Sz. No QT problems
• Easy to titrate
• Preferred for intoxications
• Preferred for seizure, etoh w/d.
• Works some for psychosis
• Preferred by patients

What if really really agitated?

- PO still preferred route if possible
- Benzodiazepines still preferred class
- Lorazepam most widely used
  - Reliable IM absorption
  - No metabolites
- Consider Midazolam

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<tr>
<th></th>
<th>Time to Sedation</th>
<th>Time to Arousal</th>
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<tr>
<td>Midazolam IM</td>
<td>18 min</td>
<td>81 min</td>
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<td>Lorazepam IM</td>
<td>32 min</td>
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<td>Haloperidol IM</td>
<td>28 min</td>
<td>126 min</td>
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Just really drunk?

- Benzos vs antipsychotics?
- Project BETA recommends haldol
- I’ll stick with ativan and avoid midazolam

Psychotic from meth?

- Ativan still good
- SGAs effective against meth psychosis.
Decompensated psych disease?

ACEP Level B: Known Psych dz

- Use an antipsychotic alone
- Or use oral benzo + antipsychotic

Expert Consensus Guideline

- “Within the limits of expert opinion and with the expectation that future research data will take precedence, these guidelines suggest that the SGAs are now preferred for agitation in the setting of primary psychiatric illnesses but that BNZs are preferred in other situations.”

Project BETA Recommendations

- SGAs recommended over haldol
- Risperidone or olanzapine if will take oral.
- Ziprasidone or olanzapine if IM


First Generation Antipsychotics

- Powerful, effective, Dopamine antagonists
- Long history
- Cheap
- Narrower range of sx
- Not favored by pts
- Not used long term
- High EPS

Extrapyramidal Symptoms

- Dystonia
- Oculogyric crisis
- Akinesia
- Akithesia
- Parkinsonism
- Tardive dyskinesia

Second Generation Antipsychotics

- Broad range of sx, multiple receptors
- Effective single agent
- Low EPS
- Preferred by pts and psychiatrists
- Shorter history
- Expensive
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<th>Drug</th>
<th>Dose</th>
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<tr>
<td>Geodon</td>
<td>20mg IM</td>
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<td>Zyprexa</td>
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<td>Regimen cost</td>
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Regimen cost: 44

NNH: Olanzapine vs Haloperidol

- Parkinsonism: Avoided every 7 pts
- Acute Dystonia: Avoided every 14 pts
- EPS: Avoided every 21 pts
- Anticholinergic Rx: Avoided every 7 pts

What if that didn’t work?

Change class?
Add more benzo?
Benzo after IM zyprexa?
Take-Down team

- “Code 100”
- 6 staff + 1 physician
- Nurse #1 runs the code
- Nurse #2 gets the meds
- Nurse #3 gets restraints
- 1 staff per limb
- Physician to determine meds.

What should I give the elderly agitated patient?

- Wait for it...
- Quiet room, low lights
- Language?
- Family and familiarity

Elderly and Agitated

- Haloperidol low dose = first line
- Extensive history (but not FDA-labeled)
- Negligible anticholinergic effects
- Minimal hypotension
- BZNs and anticholinergics can worsen sx
QTc?

- All antipsychotics can prolong QTc and predispose to torsades de pointes
- Beware if baseline EKG = QTc >500
- Droperidol received controversial FDA Black Box Warning
- Haldol IV route not FDA approved 2/2 QTc...but everyone uses it.

Based on the evidence and view that IV haloperidol was a highly effective and preferred treatment for delirium, the committee approved the use of IV haloperidol in doses < 2mg with cumulative dose of 20mg/24 hours without 12-lead ECG monitoring. Telemetry and daily ECGs would be required for single doses ≥ 2 mg or cumulative doses of ≥ 20 mg/day.

While you’re worrying

- EPS, acute dystonia,
- Neuroleptic Malignant Syndrome
- Olanzapine-->hypotension
- Olanzapine + BZN co-administration not advised.
- Ziprasidone-->More QTc prolongation but no recorded bad outcomes

What about Parkinson’s?

- What do you give?
- Quetiapine (Seroquel) is most widely used antipsychotic for dopaminergic-induced psychosis.
Summary

• Acute agitation is dangerous for you and pt
• Prevention and de-escalation is key
• Oral route preferred when possible
• BZN’s preferred for undifferentiated agitation in healthy adults
• Controversy over atypical vs typical antipsychotics in psychotic agitation
• Haloperidol most widely accepted in elderly with delirium (quetiapine in Parkinson’s)