Stabilization and Management of the Acutely Agitated or Psychotic Patient

Nathan Deal, MD[a], Michelle Hong, MD, PharmD[a,*], Anu Matorin, MD[b], Asim A. Shah, MD[c]

KEYWORDS

• Agitation • Psychomotor agitation • Psychosis • Benzodiazepines • Antipsychotics

KEY POINTS

- Management strategies should use the least restrictive interventions for the shortest duration possible.
- The use of pharmacologic agents is not to simply render a patient unconscious, but rather to control agitation and aggression to circumvent violence and facilitate further assessment of the patient.
- Lorazepam is the preferred agent for the treatment of undifferentiated acute agitation.
- Seclusion and mechanical restraints are coercive measures that should be considered methods of last resort.

INTRODUCTION

As any emergency personnel can attest, the acutely agitated or psychotic patient is no stranger to the emergency department (ED). Often they present with little or no history, but clinicians and staff are nevertheless challenged to make decisions regarding how to best manage these patients. In addition to being agitated, an acutely psychotic patient may present with hallucinations or delusions that can further

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[a] Section of Emergency Medicine, Emergency Center, Ben Taub General Hospital, Baylor College of Medicine, 1504 Taub Loop, Room EC 61, Houston, TX 77030, USA; [b] Department of Psychiatry and Behavioral Sciences, Neuropsychiatric Center, Ben Taub General Hospital, Baylor College of Medicine, 1502 Taub Loop, Room 2.126, Houston, TX 77030, USA; [c] Department of Psychiatry and Behavioral Sciences, Neuropsychiatric Center, Ben Taub General Hospital, Baylor College of Medicine, 1502 Taub Loop, Room 2.125, Houston, TX 77030, USA
* Corresponding author.
E-mail address: Michelle.Chan@bcm.edu

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complicate patient care because of poor insight and lack of cooperation.[1] When left untreated, an acutely agitated or psychotic patient can rapidly progress to hostile and violent behavior.

According to the US Bureau of Labor Statistics, there is an increasing trend of violent acts toward workers in the health care and social assistance industries, with nonfatal incidences occurring almost 5 times more often than in all other industries combined.[2] There is also evidence to suggest that many instances of assault go unreported.[3–5] Within the hospital itself, EDs are among the most common settings for violence to occur,[6] with some studies showing that more than 70% of emergency staff report being the victim of at least 1 violent act over a 1-year period.[7,8]

Psychosis is a syndrome that impairs a patient's ability to interact appropriately with reality. According to the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5), a defining feature of psychotic disorders is abnormal motor behavior, which can involve unpredictable agitation. DSM-5 goes on to define psychomotor agitation as excessive motor activity associated with a feeling of inner tension.[9] Cohen-Mansfield and Billig[10] defined agitation as "inappropriate verbal, vocal, or motor activity that is, not judged by an outside observer to result directly from the needs or confusion of the agitated individual." Regardless of the definition, the key concept to understand is that agitation is a symptom[10,11] of many medical and psychiatric disorders that can manifest itself both verbally and physically along a spectrum of severity. As a result, not all presentations of agitation require emergency intervention. To help determine which presentations warrant intervention, an expert consensus described 5 features that define clinically significant agitation.[12]

1. Abnormal and excessive verbal behavior such as shouting, cursing, threatening, or screaming
2. Abnormal and excessive physically aggressive behavior such as pushing, shoving, actively resisting care, repeatedly attempting to elope, or excessive threatening gestures
3. Heightened arousal
4. Symptoms cause clinically significant disruption of patient's functioning
5. Abnormal excessive or purposeless motor behavior

Ultimately these are all behaviors that are dynamic in nature, with several studies supporting the predictive value of agitation for subsequent aggressive or violent behavior,[13] in contrast to the traditional approach of assessing static risk factors for violent behavior such as history of prior violence, substance abuse, and certain psychiatric disorders including schizophrenia, borderline or antisocial personality disorder, acute mania, and psychotic depression,[14] information which may not be immediately available in the emergency setting.

PATHOPHYSIOLOGY

Although the pathophysiology of agitation is not well elucidated, it is thought to be due to the imbalance of certain neurotransmitters, particularly serotonin, dopamine, norepinephrine, and γ-aminobutyric acid (GABA).[15,16] In particular, increases in serotonin or GABA, or decreases in dopamine or norepinephrine, can lead to or contribute to agitation.[15] The variability in presentation is in part due to the many organic and inorganic causes of agitation. Well-established causes of agitation are listed in **Box 1**. In addition, many other unusual but potential causes of acute agitation or psychosis in the ED have been reported in the literature, including

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