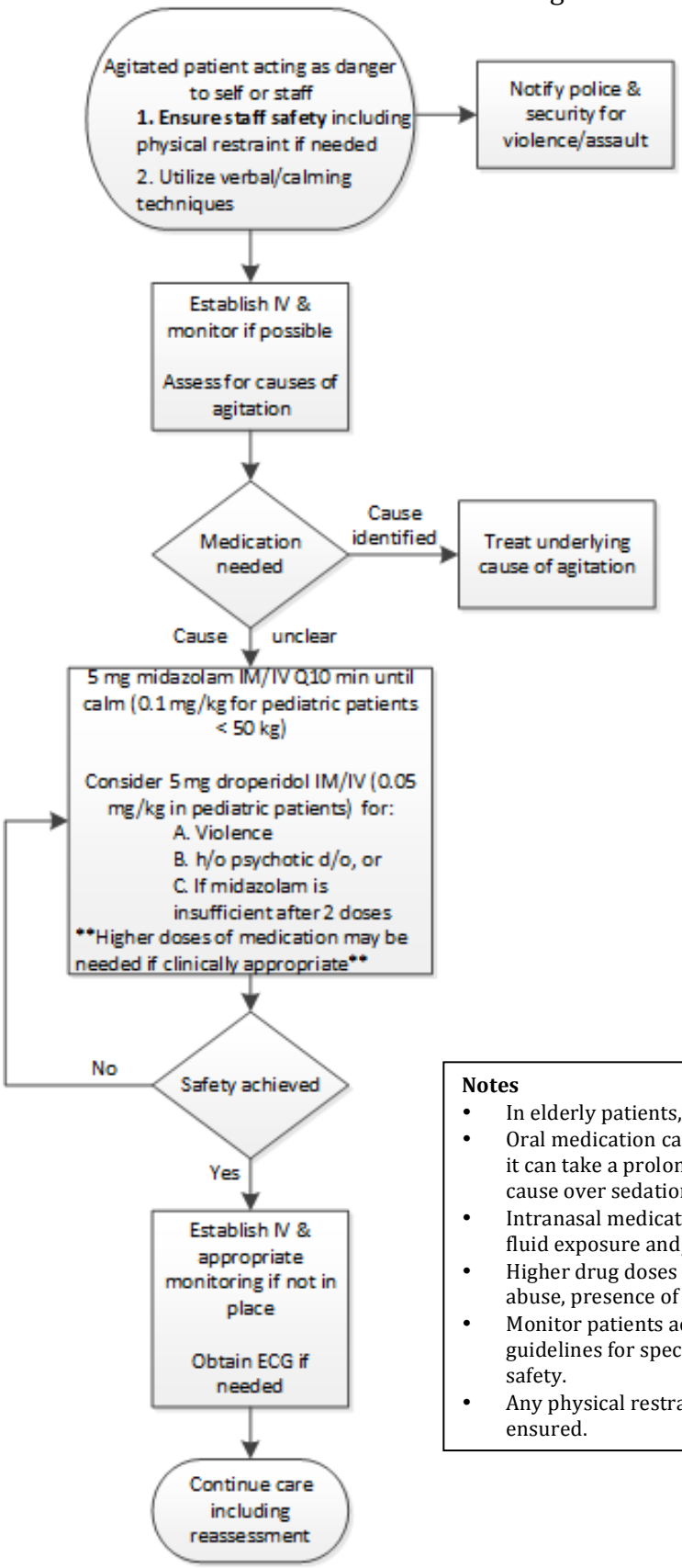
Undifferentiated Psychomotor Agitation Care Pathway

Step 1: This step is intended for the initial, short-term management of agitated and violent patients who are undifferentiated and require sedation in order to complete an assessment. This is not definitive management.



Notes

- In elderly patients, reduce doses by half
- Oral medication can be considered in some cooperative patients, but it can take a prolonged time to take any effect. Additive effect often cause over sedation if parenteral medications are later given.
- Intranasal medications not recommended when there is risk of body fluid exposure and/or lack of concentrated drug formulations.
- Higher drug doses may be required than listed (e.g. chronic EtOH abuse, presence of inducers of CytP450)
- Monitor patients according to institutional and departmental guidelines for specific agents used to ensure efficacy and patient safety.
- Any physical restraints should be removed as soon as safety is ensured.

Step 2: Definitive management of agitation should be guided by the underlying cause of the agitation.

There are many behavioral, psychiatric, toxic, and medical causes of agitation. Definitive treatment of the underlying cause is key to optimal care & patient safety.

Table 1. Common causes of agitation and therapy recommendations

Underlying Cause	Treatment
Intoxication	• Benzodiazepines are the safest option. • Antipsychotics can dangerously interact with some drugs, and thus are less desirable & can be unsafe. • Selection of agent: Should be guided by the expected timeframe of agitation based on duration of action of intoxicant.
CNS Stimulants or Psychotropics • **Short acting**	• Midazolam IV Push given in intermittent doses (expected duration 90 min; less in chronic alcoholics or agents which induce CytP450 metabolism).
• **Longer acting**	• Lorazepam IV Push given in intermittent 1 mg doses (expected onset 15-20'; expected duration 2+ hours; less in chronic alcoholics). Preferred agent in liver disease.
Withdrawal syndromes (Life-threatening if EtOH or benzodiazepine; not life-threatening if opioids, cocaine)	• Treat with agonist of appropriate receptor. • Use long acting benzodiazepines (and escalating doses if needed) for continued efficacy and safety. • Sub-optimal initial doses will require larger cumulative doses. • In conjunction, provide adequate hydration to volume resuscitate and reduce sympathomimetic symptoms.
Primary psychosis	• Longer acting antipsychotic medications (dopamine antagonists). • Haloperidol remains the standard. Expect onset (Haloperidol IM 20 min; Haloperidol PO 2 hours).
Metabolic derangement and hypoglycemia	• Treat underlying abnormality to control agitation.
Pain	• Treat underlying pain to control agitation. Sedation is not recommended.
Delirium	• Treatment of primary agitated delirium is difficult. • Benzodiazepines and antipsychotic medication are associated with risks in primary delirium and dementia (elderly are disproportionately affected). • Treat case-by-case.
Infection	• Address source control (including appropriate antimicrobials). Changes can be slow to improve. • Goal is to decrease oxygen delivery & utilization • Benzodiazepines remain safest option; reduce doses in elderly.
CNS lesion/elevated intracranial pressure • Agitation often first sign of elevated ICP • Suspect if history of trauma, known neoplastic disease, or focal neurologic deficits	• Address underlying abnormality • Temporize with ICP-lowering measures as needed (e.g. mannitol/hypertonic saline, hyperventilation etc). • Sedate only if needed to ensure staff safety. • Benzodiazepines remain the safest treatment
Hypoxia/respiratory acidosis	• Correct oxygenation and ventilation • Further sedation not advised if breathing spontaneously (hypopnea may worsen underlying problem).