

Acute Behavioural Disturbance Discussion Forum

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Case 1

- ▶ A 35 year old 100 kg man was brought in by police and ambulance officers after a domestic violence incident. He punched his girlfriend and tried to strangle her because she is the 'devil'.
- ▶ The ambulance officers stated that he has a history of alcohol and polysubstance abuse including cocaine and methamphetamine and is known to have a psychiatric illness.

At the ED

- ▶ Patient was awake, alert and coherent. No observation could be done as patient refused to be assessed.
- ▶ He was handcuffed by police. The police wanted to charge the patient when he is discharged from the hospital.
- ▶ He wants to leave as the doomsday is coming and he has to go and save the world.
- ▶ ***What is your risk assessment?***

Provisional Diagnosis

- ▶ A 33 year old man presents with drug induced psychosis.
- ▶ What is the next step in the management of this patient?

- ▶ This patient was sedated with 10 + 10 mg IM droperidol. He was drowsy but rousable.
- ▶ All vital signs and ECG were normal. Otherwise clinically well.
- ▶ The police and security officers left ED.
- ▶ 4 hours later, the patient woke up.

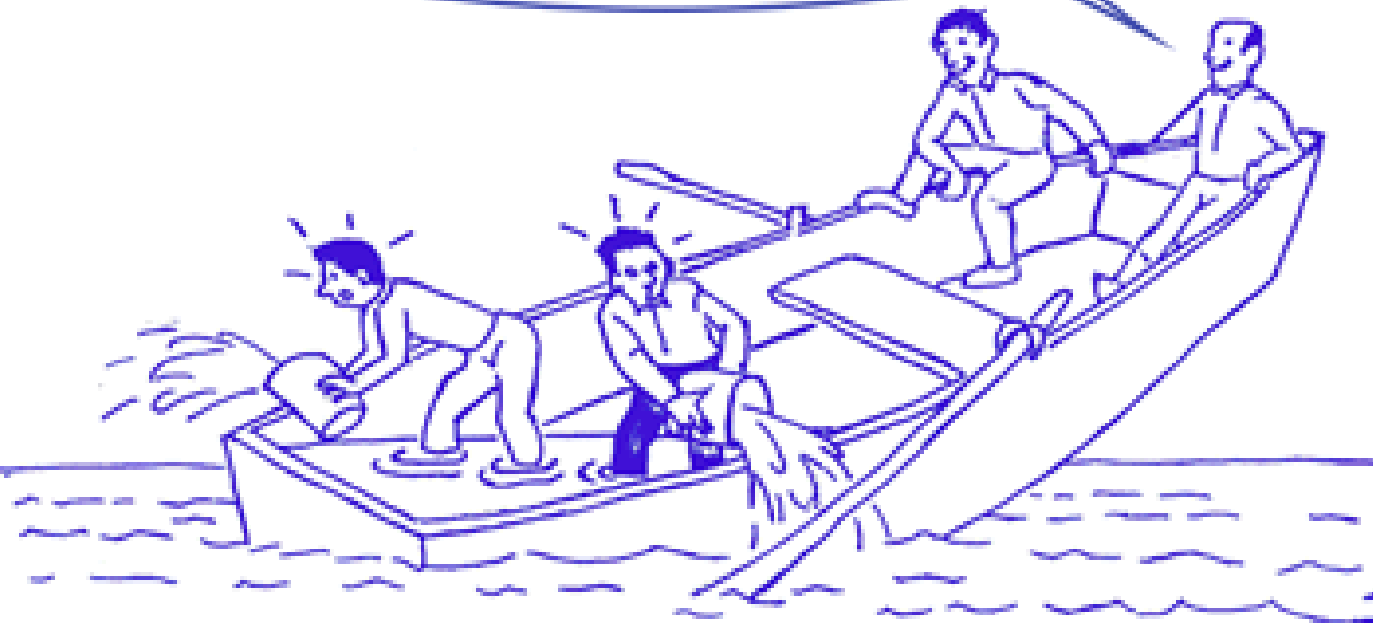
Who should now review this patient?

- ▶ Is it the Emergency Physician?
 - ▶ Is it the mental health doctor/CNC?
 - ▶ Is it drug and alcohol CNC?
 - ▶ Is it all three and in what order?
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- ▶ What happens if there is no D&A and MH service on site?

Progress

- ▶ The patient has no apparent medical illness.
- ▶ MH team is contacted but they are busy in the psychiatry unit and will not be able to come immediately and assess this patient.
- ▶ This is now 12 pm and the patient wants to go home.
- ▶ How should this situation be handled?

*SURE GLAD THE HOLE
ISN'T AT OUR END!*



Case 2

- ▶ A 39 year old man presented to a regional hospital after taking an overdose of quetiapine 1 gm and cogentin 60 mg and alcohol while visiting his ex-partner.
- ▶ He became aggressive & threatened to jump off the balcony. He was brought in by police at 1900 hr.
- ▶ He was verbally & physically abusive requiring chemical restraint of 20 mg IV midazolam.
- ▶ On arrival at the ED, HR 105, BP 160/90, pupils 5 mm, temp 37.2°C, GCS 15.
- ▶ ***What is your risk assessment?***

Provisional diagnosis

- ▶ 39 year old man presents with a drug induced anti-cholinergic delirium.

Past History

- ▶ Paranoid schizophrenia
- ▶ Bipolar disorder
- ▶ Anti-social personality disorder
- ▶ Alcohol and drug abuse

Questions

- ▶ Your hospital does not have a toxicology unit.
- ▶ Which team should admit this patient?
- ▶ How and where should this patient be managed?
- ▶ When should this patient have a mental health assessment?

Progress

- ▶ Total sedation from 1900 to 0600 hr next morning was
 - ▶ Midazolam 112.5 mg
 - ▶ Olanzapine 30 mg
 - ▶ Clonazepam 12 mg
 - ▶ Propofol 450 mg
 - ▶ Clopixol 100 mg
 - ▶ Droperidol 15 mg

Progress

- ▶ He became over-sedated and has aspiration pneumonia.
- ▶ Treated with IV antibiotics.
- ▶ Transferred to psychiatric unit on D3.

Approach

- ▶ **Team approach**, call security, Code Black.
- ▶ Verbal de-escalation & offer oral sedation
- ▶ Chemical sedation with 5 point physical restraint
- ▶ Droperidol 10 mg IMI.
- ▶ If patient failed to respond within 15-20 minutes, to give additional 10 mg droperidol IMI.
- ▶ Consider alternative agent if this failed to keep patient sedated.
- ▶ Monitor HR, BP, GCS, ECG, O2 saturation with 1:1 nursing.
- ▶ Physical exam to exclude other causes of acute delirium.

Team Work

- ▶ Drug & Alcohol induced delirium & psychosis require a team approach with emergency physician, toxicologist, mental health, drug & alcohol personnel working together & often at the same time to provide the best possible plan for patient.



TEAMWORK

Because none of us are as bad ass as all of us.

A graphic of a spiral-bound notebook with a white page and a black border. The spiral binding is at the top. The text is centered on the page.

TEAMWORK

coming together is a beginning

keeping together is progress

working together is success

- Henry Ford