

THE POTENTIALLY VIOLENT PATIENT IN THE ED

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DISCLOSURE

- I have no conflicts of interest or financial disclosures pertaining to this presentation
- (unlike Nancy Pelosi)

LITERATURE

- Violence in the Emergency Department: A Survey of Health Care Workers. CAN MED ASSOC J, 1999
- Documents a General Feeling of Unease Amongst ED Workers (multiple literature sources)

LITERATURE

- Violent Patients and the Prehospital Providers
- ANN EMERG MED, 1993 (TINTINALLI)
- Urges Education of EMS on self-defense and violence assessment strategies

LITERATURE

- Minimizing gang violence in the ED
- Urges education of staff on preventive measures

REVIEW OF PSYCH TERMS

- Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (1994)
- Uses criteria based on signs and symptoms
- AXIS I: Mental Disorders
- AXIS II: Personality and developmental disorders
- AXIS III: Medical conditions
- AXIS IV-V: Psychosocial stressors and adaptive responses

DECISION TREE

- Is this a variant of a medical condition that I have to pursue, diagnose and treat?
- Or is this a variant of a psychiatric condition that I may have to sedate/control but not definitively treat?

AXIS I

- DEMENTIA- Patients from home or nursing home of personal care home brought in because of threats of violence with underlying dementia
- Elderly
- Somewhat stable
- Off meds
- Nighttime paranoia (sundown sickness)
- One could argue that this is a medical disorder

PSYCHOSIS

- Delusions and hallucinations common in schizophrenia
- Persecutory (paranoid) delusions may lead to violence

DEMENTIA

- Over-all loss of higher cognitive function (memory, judgment)
- New onset deserves testing for organic cause
- Exacerbations deserve strong consideration for testing

DELERIUM

- Acute Course
- Variable Alertness
- Strong reaction to hallucinations may lead to violence or disruptive behavior
- May be a toxicity

MOOD DISORDERS

- Depression
- Mania

ANXIETY DISORDERS

- Panic
- Phobias
- PTSD

SOMATIFORM

- Fibromyalgia, whiplash, etc

AXIS II PERSONALITY DISORDERS

- Malingering
- Antisocial
- Behaviors that are lifelong and cause impairment in social function
- Kids with adjustment disorders or are brought in by parents for disruptive behavior, stealing, etc

VIOLENCE AND SAFETY

- Preparation
- Staff Education
- Appropriate Room for evaluation
- Trained Security
- Camera?
- Studies have shown that up to 4-8% of psychiatric patients may carry a weapon

DEFINITIONS

- Aggression: forceful or assaultive physical action
- Agitation: psychological/motor hyperactivity
- Anger: an emotional state (eg, I am angry at those that oppose the Fair Tax)

POTENTIAL VIOLENCE AVOIDANCE

- Escape route
- Calming manner
- Quiet space
- Offering comfort (blanket, water)
- Avoid direct eye contact
- Wandering
- Constant re-assurance
- Firm control of unwanted behavior

RESTRAINTS

- From 25% to <1% use in different ED's
- High percentage of restrained patients have a medical cause
- Add chemical when violent resistance to restraints continues
- EMS "sandwich"

RESTRAINTS

- Medical Problem out of control (ETOH, Diabetes)
- Need to restrain in order to gain IV access, administer drugs
- Need to restrain in order to perform diagnostic tests (LP, CT) (Etomidate?)
- Best for patient safety

Restraints

- Functional psychosis-restrain first, diagnose later (ie, the cause of the behavior is not first priority)
- Restraints used to transition to chemicals

Restraints

- Personality disorder-restraints usually not needed
- All teenagers fit this category by definition

RESTRAIN PATIENT

- Calm reassurance: 5 restrainers
- One person restrains each limb, one "supervisor"
- Reversible cause (sugar?)
- Soft leathers vs chemicals

Chemical Restraints

- Neuroleptics
- Earliest: amobarbital
- 1950's: Thorazine (chlorpromazine) (hypotension)

CHEMICALS

- Benzodiazepines
 - Safe
 - Short Duration
 - Can be used with anti-psychotic

Chemical Restraints

- Haloperidol (Haldol) (antipsychotic)
- Oral, IM, IV
- Consider oral route as it is evidence for implied consent (pt willing to ingest)
- 5-10mg younger patients
- 2mg elderly
- Repeat every 30-60 min

CHEMICALS

- Haldol parenteral: 2-5 MG
- Plus/minus benzos
- Droperidol works great 2.5-10Mg IV, IM (sedation, not antipsychotic) (may last hours)
- After sedation takes effect. Intensify monitoring (ignoring these patients is risky)
- DON'T FORGET TEMP!

HALOPERIDOL SIDE EFFECTS

- Dystonia: Benztropine ,2mg; diphenhydramine, 25-50mg
- Hypotension: fluids
- Not in pregnancy
- Avoid in organic brain syndromes, intoxications- (anticholinergic potentiation)

Ziprasidone (Geodon)

- 20 mg po
- Rapid acting antipsychotic
- Prolongs QT interval
- NMS
- Tardive Dyskinesia
- Unlikely with one dose

NEUROLEPTIC MALIGNANT SYNDROME

- Results from treatment with neuroleptics (1% incidence)
- May occur anytime after treatment. Usually first 10 days
- Retreatment does not result in NMS (usually)
- Usual culprits: haloperidol, thiothixine
- Clozapine, risperidone, olanzapine also
- Once pt calm, consider re-taking temp

NMS CONTINUED

- Hyperthermia, muscle rigidity, encephalopathy
- Autonomic instability (BP, P, T)
- CK, Myoglobin increases
- Lasts up to 2 weeks
- It is hard to detect co-morbid conditions (eg, meningitis)
- Morbidity up to 20% (renal failure)

NMS MANAGEMENT

- Fluids to manage myoglobinuria
- Cooling (same as for arrest)
- ICU
- DVT Prophylaxis?
- Dantrolene 3-5MG/KG IV TID (Blocks muscle calcium release)
- Bromocriptine 5MG QID per NG Tube (dopamine agonist)

NMS CONTINUED

- Electrolyte imbalance common
- Easily confused with encephalitis
- Differential: serotonin syndrome, CNS infections, drug toxicities, dystonic reactions
- Workup: coags, lytes, CXR, LP, CBC, BMP, HeadCT, Poss ABG.

NMS MANAGEMENT

- No literature support except anecdotal for any of the treatments

SEROTONIN SYNDROME

- Encephalopathy, hyperreflexia, nausea, vomiting, autonomic instability
- Usually SSRI + Tricyclics or MAO inhibitors-ie: synergistic effect on serotonin
- Treatment: support plus d/c meds
- Fluids and labs similar to NMS, monitor

In Summary

- Do no harm to the patient or yourself

SECURE SECLUSION

- Dedicated Room: Lockable, Nothing on wall, Private BR
- Security
- Window
- Wandering
- A sheet can be used for strangulation

INITIAL VIOLENT EPISODE

- Cause not relevant in first few minutes
- Protect patient
- Protect staff
- Protect yourself (DR should not, if possible be involved physically)

PHYSICAL ASSAULT

- Try to avoid by having escape route
- Avoid weapon by wandering/search
- Don't allow patient access to weapons/sharps (Detroit Receiving)
- Be calm
- Don't argue, especially if pt has weapon

DISPOSITION

- Chemically altered patients can be discharged after drug metabolized and pt judged to be non-violent
- Psychotic patients should have a psychiatric consult

CONCLUSION

- Be careful out there
- Always think medical cause first (first time for this patient, very young, elderly)
- When in doubt, try a history and physical