Chapter 5
Agitation

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Introduction

Patients with agitation are frequently encountered in an emergency department (ED) or psychiatric emergency service (PES). Agitation is not a disease state but actually a cluster of symptoms. Core symptoms and signs of agitation generally include irritability, excessive or semi-purposeful motor activity (also known as "psychomotor agitation"), heightened responsiveness to internal and external stimuli, and an unstable course. Agitation can be associated with both psychiatric and non-psychiatric conditions. Until agitation is appropriately treated, evaluation and treatment of the underlying issue may be delayed.

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Symptoms

Internal restlessness
Feeling out of control
Feeling irritable/argumentative
Heightened responsiveness to stimuli (internal and external)

Signs

Increased and excessive semi-purposeful motor activity (pacing, etc.)
Irritability
Verbal outbursts
Physical aggression

Life-Threatening Symptoms/Signs Related to Medical Causes

Symptoms

Loss of memory, disorientation
Severe headache
Extreme muscle stiffness or weakness
Heat intolerance
Unintentional weight loss
Psychosis (new onset)
Difficulty breathing

Signs

Abnormal vital signs: pulse, blood pressure, or temperature
Overt trauma
Anisocoria (unequal pupil size)
Slurred speech
Incoordination

Seizures
Hemiparesis

Differential: When a patient first arrives to the ED or PES and demonstrates agitation, it is helpful to think of agitation as falling into one of four main groups to guide immediate treatment. These include agitation associated with delirium; agitation due to intoxication; agitation associated with psychosis; and undifferentiated agitation (see "Tool" at end of chapter). After immediate treatment, further workup can be performed to determine the underlying cause of agitation. An extensive (though not exhaustive) differential of causes of agitation include the following:

Acute pain
Head trauma
Infection
Encephalitis
Encephalopathy
Toxins
Metabolic issue
Hypoxia
Hyperthyroidism
Neurologic disease
Supratherapeutic dosing of medications
Recreational drug intoxication
Recreational drug withdrawal
Exacerbation of primary psychiatric disorder

Treatment

Acute:

- In all cases, verbal de-escalation techniques should be tried.
- In order to determine best pharmacological treatment.
  - If the agitation is associated with delirium and alcohol or benzodiazepine withdrawal is not suspected, consider

medical causes first in the ED setting. Common causes include hypoglycemia, hypoxia, head injury, or thyroid disease. Treat the underlying cause first before giving medications (best evidence is for oral risperidone and oral olanzapine).

- If the agitation is associated with delirium and this is likely due to alcohol or benzodiazepine withdrawal, benzodiazepines are the first line treatment.
- If the agitation is associated with stimulant intoxication, benzodiazepines are also first line.
- If the agitation is because of a CNS depressant (like alcohol), protect the airway first. Non-pharmacologic interventions such as simply turning down the lights are first line. If medications are needed, first-generation antipsychotics like haloperidol are likely safer than benzodiazepines.
- If the agitation is associated with psychosis in a patient with a known psychiatric disorder, second-generation antipsychotics are preferred (best evidence for risperidone or olanzapine). If the home medication (anti-psychotic) is known, consider dosing with this medication.
- If the cause of the agitation is unknown and there is no psychosis, treat like alcohol or benzodiazepine withdrawal.
- If the cause of the agitation is unknown and there is psychosis, treat as if the patient had a known psychiatric disorder.
- Restraints are occasionally needed if the agitation is severe and the patient is actively trying to hurt self or others. Restraints should be used as a last resort only and avoided if at all possible. If used, frequent reassessment and patient debriefing is necessary.

Long-term treatment: The long-term treatment is really one of prevention. Agitation is an acute condition but the disease state that produces agitation may be chronic. If the agitation is related to a chronic illness, the treatment for the primary illness may need to be modified to help prevent breakthrough symptoms.

Tool

Protocol for Treatment of Agitation

References

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3. Wilson MP, Pepper D, Currier GW, et al. The psychopharmacology of agitation: consensus statement of the American Association for Emergency Psychiatry Project BETA Psychopharmacology Workgroup. West J Emerg Med. 2012;13(1):26–34.