mario guarino aspirante medico d'urgenza
Napoli 18 Novembre 2016

AGITATED PATIENT MANAGEMENT IN EMERGENCY DEPARTEMENT

Una domanda...

...cos'è la vita?

Chiamata della Centrale Operativa:

- Codice Giallo
- Agitazione psicomotoria
- Paziente con doppia diagnosi ai domiciliari
- E' armato di coltello!!!

Io: ***"c….o chiama la Polizia!"***

CO: ***"vabbè tu comicia ad andare e poi mi fai sapere…"***

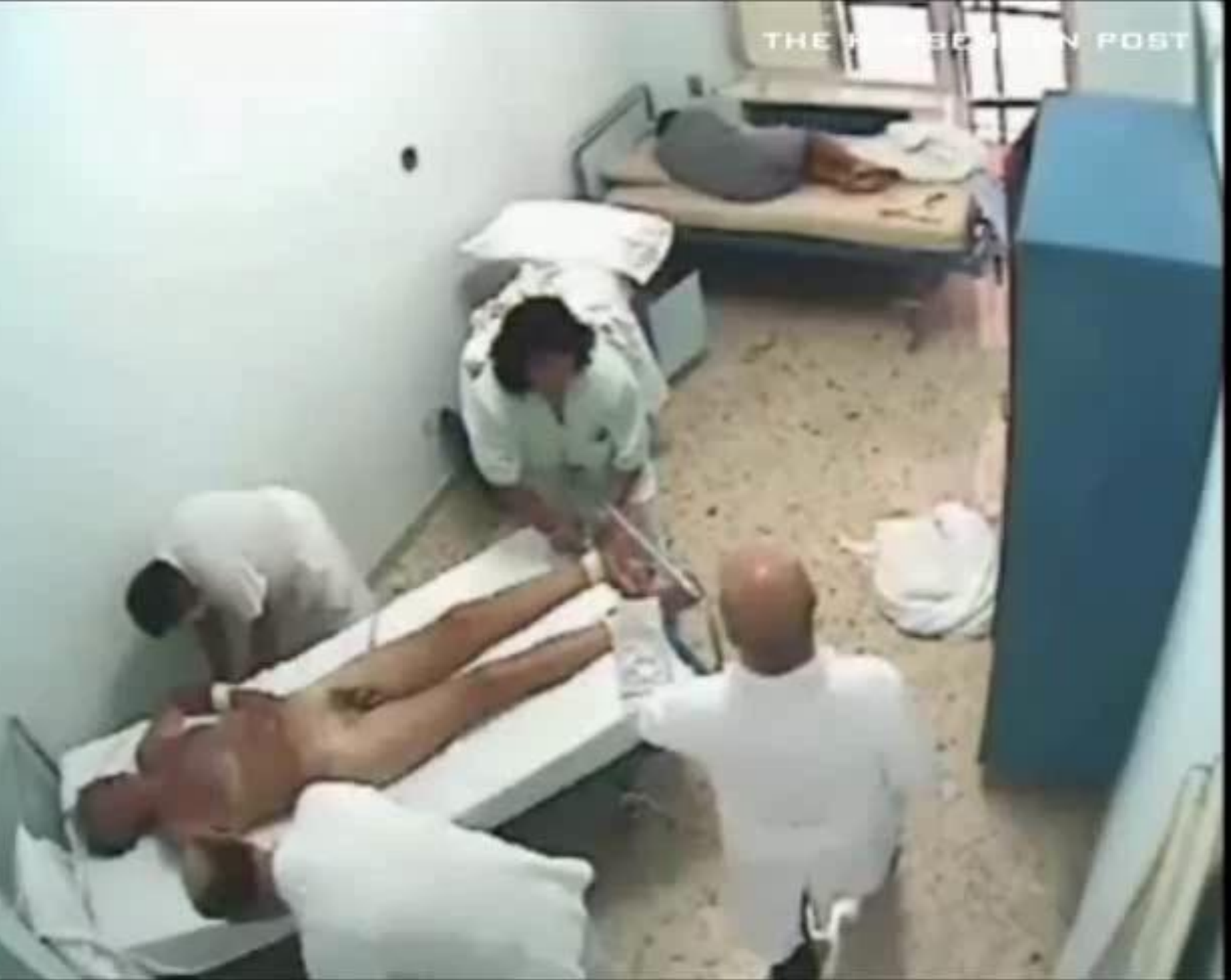
Nunzio, 34 anni, circa 75 kg.
Cocainomane, psicosi cronica, ben 3 TSO in curriculum
Agli arresti domiciliari per stalking e tentato omicidio
Agitato (ha un coltello in mano e minaccia il padre!)
Scena non sicura… ovviamente!
Quello str…o della CO non ha allertato la Polizia
Quick-look: Agitato ma discretamente collaborante con la Polizia
A: vie aeree pervie
B:nun se po' fà
C: nun se po' fà
D: CGS 15
E: nun se po' fa **NRS?**

AGITATED PATIENT MANAGEMENT IN EMERGENCY DEPARTEMENT

LA STAMPA

Morto per un Tso: uno psichiatra e tre vigili a processo

È il 5 agosto dell'anno scorso. , un ragazzone di 45 anni, da tempo affetto da schizofrenia paranoide, è seduto su una panchina in piazza Umbria come tutti i giorni. Da mesi rifiuta le cure, il suo psichiatra - un medico dell'Asl To2 - ha deciso che è indispensabile praticargli un Tso. Arriva sul posto, lo raggiungono tre vigili del nucleo servizi mirati. Andrea Soldi rifiuta il trattamento. Ha una corporatura imponente, pesa 120 chili, si ancora alla sua panchina, non vuole muoversi. Allora - secondo la ricostruzione della procura - medico e vigili decidono di portarlo in ospedale con la forza. I civich lo immobilizzano da dietro, lo ammanettano e lo stendono a pancia in giù su una barella, caricandolo in ambulanza. Lo psichiatra sale sulla sua auto e si dirige in ospedale. **Quando arriva al pronto soccorso è in condizioni gravissime. Muore poco dopo.**


THE POST

ALLEGATO ALLA DELIBERA N. 1904 DEL 14 OTTOBRE 2016

RACCOMANDAZIONE PER IL SUPERAMENTO DELLA CONTENZIONE

5. CONTENZIONE

La contenzione sotto il profilo sanitario è da considerare un atto non terapeutico: non cura, non previene e non riabilita e può causare lesioni, grave disabilità e morte della persona assistita.

Per contenzione delle persone assistite si intende l'atto di natura eccezionale applicabile solo quando tutte le altre misure alternative si siano dimostrate inefficaci, che, attraverso l'utilizzo di dispositivi fisici, farmacologici o ambientali, in qualche modo limita la libertà e la capacità di movimenti volontari o comportamenti della persona assistita allo scopo di controllarla o di impedirle di recare danni a sé o ad altri.

Definition of agitation

- Despite multiple attempts at defining agitation, there is still no unequivocal agreement.[1] Some of these definitions are:

Lindenmayer 2000[2]	The key features generally present in patients with agitation including restlessness with excessive or semi purposeful motor activity, irritability, heightened responsiveness to internal and external stimuli, and an unstable clinical course
Hankin et al. 2011[3]	Agitation is a behavioural syndrome characterized by excessive or inappropriate motor or verbal activity, and often precedes, and is distinguished from, physical aggression
DSM-5 2013[4]	Agitation is an excessive motor activity associated with a feeling of inner tension. This activity is usually non-productive and repetitious and consists of behaviors such as pacing, fidgeting, wringing of the hands, pulling of clothes and inability to sit still
De Pablo et al.[5]	Agitation is a state of psychological and motor hyperactivity manifested as an uncontrolled increase of motor activity and/or feeling of inner restlessness with important emotional arousal

References

2016;17(2):86–128.

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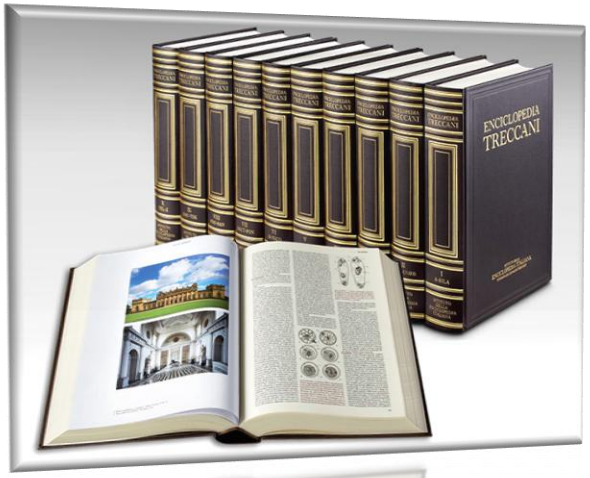
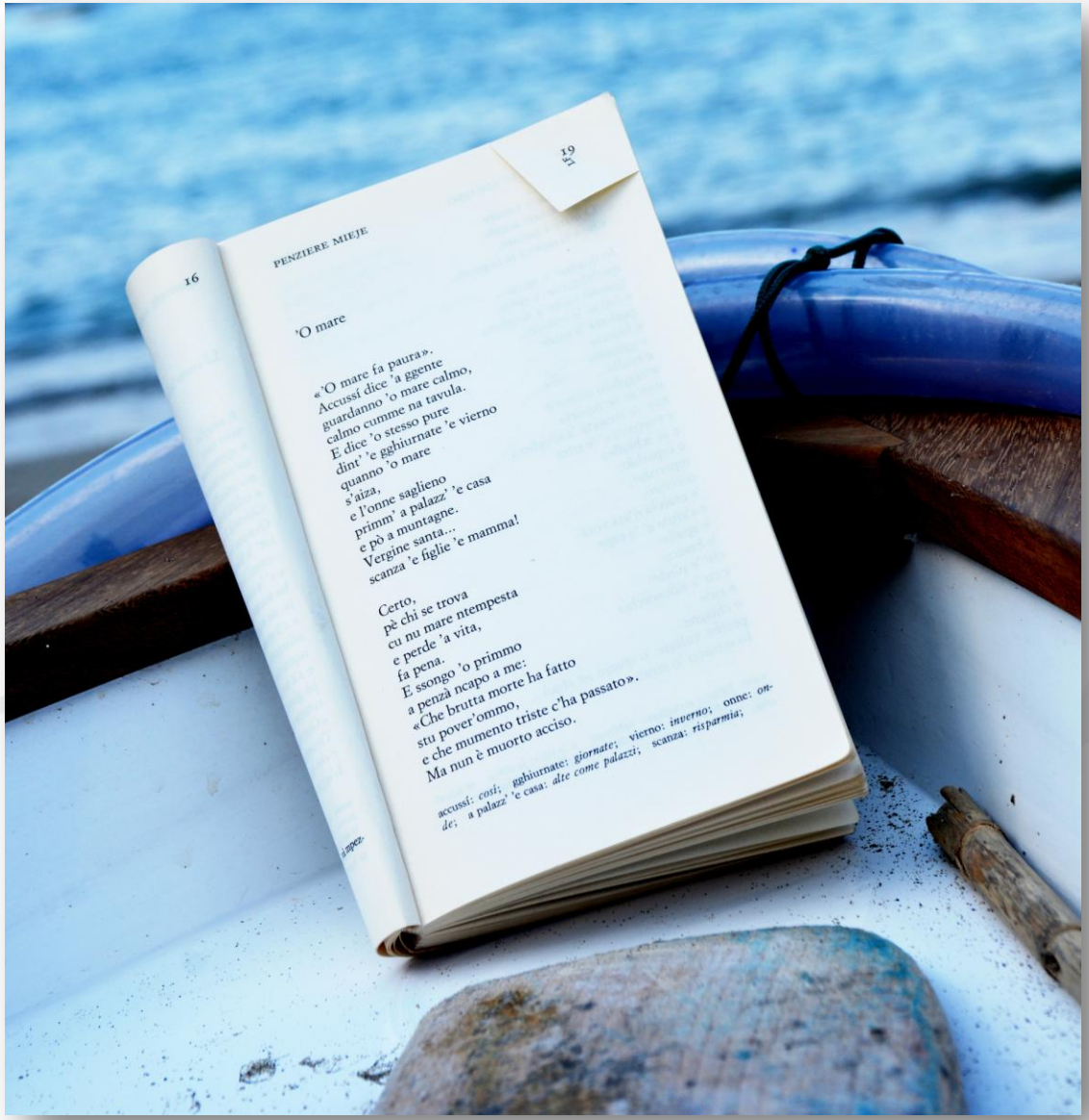
- de Pablo J, Jiménez Fàbrega X, Pérez V, Garcia G, Garcia-Ribera C, Gascón J, et al. Protocols, codis d'activació i circuits d'atenció urgent a Barcelona ciutat. Malalts amb agitació psicomotora.



agitato agg. e s. m. [part. pass. di *agitare*]. – **1.** agg. **a.** Mosso, turbato, eccitato: *il mare era molto a.*; *mostrarsi, essere, apparire agitato*. **b.** Didascalia musicale (talvolta precisata: *presto a.*; *allegro a.*; ecc.) che prescrive una esecuzione in movimento concitato ed esprimente turbamento. **2.** s. m., disus. Malato di mente in preda a manifestazioni di eccitamento: *reparto agitati*, padiglione di ospedale psichiatrico riservato in passato a questo tipo di malati (fig. scherz., ambiente turbolento). ◆ Avv. **agitataménte**, con agitazione, in modo visivamente agitato, concitato: *parlare, discutere, gesticolare agitatamente*; *camminava agitatamente su e giù per la stanza*.



Io quanno 'o sento,
specialmente 'e notte,
cumme stevo dicenno,
nun è ca dico:
"'O mare fa paura",
ma dico:
"'O mare sta facenno 'o mare".

TABLE 1

CONDITIONS ASSOCIATED WITH AGITATION[22-27]

Medical causes:

- Thyrotoxicosis
- Encephalitis
- Meningitis
- Sepsis
- Brain trauma
- Dementia
- Delirium
- Seizure disorders

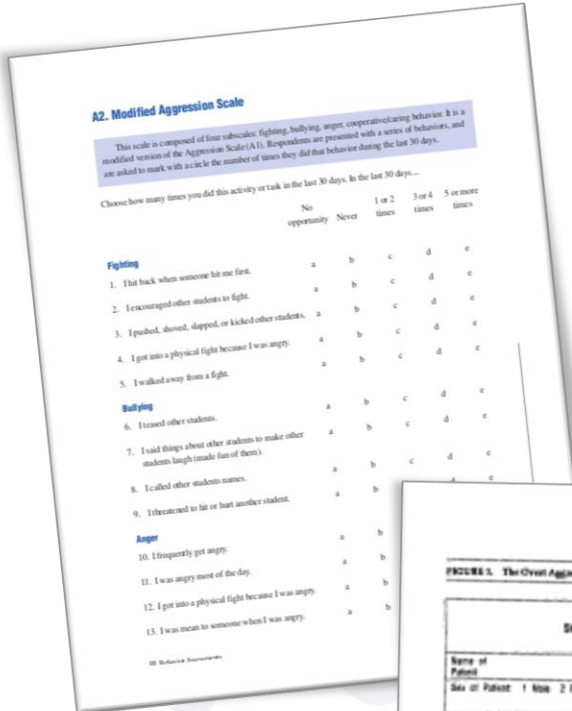
Toxicity:

- Intoxication (alcohol, cocaine, methamphetamine)
- Alcohol withdrawal

Psychiatric disease:

- Schizophrenia
- Schizoaffective disorder
- Schizophreniform disorder
- Brief psychotic disorder
- Bipolar disorder
- Borderline personality disorder
- Obsessive-compulsive disorder
- Panic disorder
- Posttraumatic stress disorder

Ng AT, Zeller SL, Rhoades RW. *Primary Psychiatry.* Vol 17, No 8. 2010.



A2. Modified Aggression Scale

This scale is composed of four subscales: fighting, bullying, anger, cooperative/caring behavior. It is a modified version of the Aggression Scale (A1). Respondents are presented with a series of behaviors, and are asked to mark with a circle the number of times they did that behavior during the last 30 days.

Choose how many times you did this activity or task in the last 30 days. In the last 30 days....

	No opportunity	Never	1 or 2 times	3 or 4 times	5 or more times
Fighting					
1. I hit back when someone hit me first.	a	b	c	d	e
2. I encouraged other students to fight.	a	b	c	d	e
3. I pushed, shoved, slapped, or kicked other students.	a	b	c	d	e
4. I got into a physical fight because I was angry.	a	b	c	d	e
5. I walked away from a fight.	a	b	c	d	e
Bullying					
6. I teased other students.	a	b	c	d	e
7. I said things about other students to make other students laugh (made fun of them).	a	b	c	d	e
8. I called other students names.	a	b			
9. I threatened to hit or hurt another student.	a	b			
Anger					
10. I frequently get angry.	a	b			
11. I was angry most of the day.	a	b			
12. I got into a physical fight because I was angry.	a	b			
13. I was mean to someone when I was angry.	a	b			

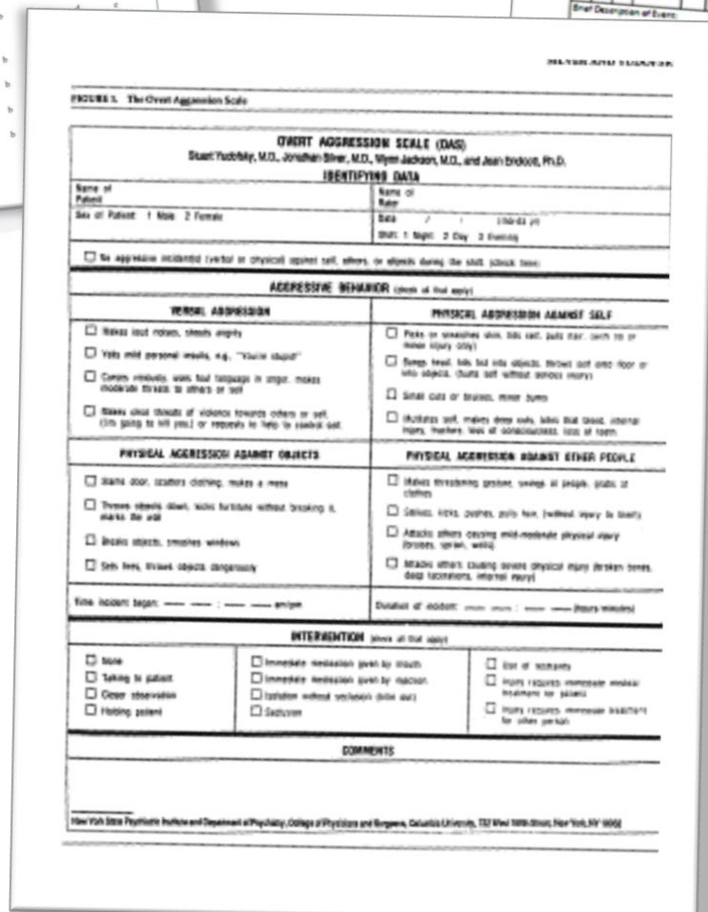


FIGURE 1. The Overt Aggression Scale

OVERT AGGRESSION SCALE (OAS)

Stuart Yudofsky, M.D., Jonathan Silver, M.D., Wynn Jackson, M.D., and Jean Endicott, Ph.D.

IDENTIFYING DATA

Name of Patient	Name of Rater
Sex of Patient: 1 Male 2 Female	Date / / (mo/da/yr)
	Shift: 1 Night 2 Day 3 Evening

☐ No aggressive incident(s) (verbal or physical) against self, others, or objects during the shift (check here)

AGGRESSIVE BEHAVIOR (check all that apply)

VERBAL AGGRESSION	PHYSICAL AGGRESSION AGAINST SELF
☐ Makes loud noises, shouts angrily	☐ Picks or scratches skin, hits self, pulls hair (with no or minor injury only)
☐ Yells mild personal insults, e.g., "You're stupid!"	☐ Bangs head, hits fist into objects, throws self onto floor or into objects (hurts self without serious injury)
☐ Curses viciously, uses foul language in anger, makes moderate threats to others or self	☐ Small cuts or bruises, minor burns
☐ Makes clear threats of violence toward others or self (I'm going to kill you.) or requests to help to control self	☐ Mutilates self, makes deep cuts, bites that bleed, internal injury, fracture, loss of consciousness, loss of teeth

PHYSICAL AGGRESSION AGAINST OBJECTS	PHYSICAL AGGRESSION AGAINST OTHER PEOPLE
☐ Slams door, scatters clothing, makes a mess	☐ Makes threatening gesture, swings at people, grabs at clothes
☐ Throws objects down, kicks furniture without breaking it, marks the wall	☐ Strikes, kicks, pushes, pulls hair (without injury to them)
☐ Breaks objects, smashes windows	☐ Attacks others causing mild-moderate physical injury (bruises, sprain, welts)
☐ Sets fires, throws objects dangerously	☐ Attacks others causing severe physical injury (broken bones, deep lacerations, internal injury)

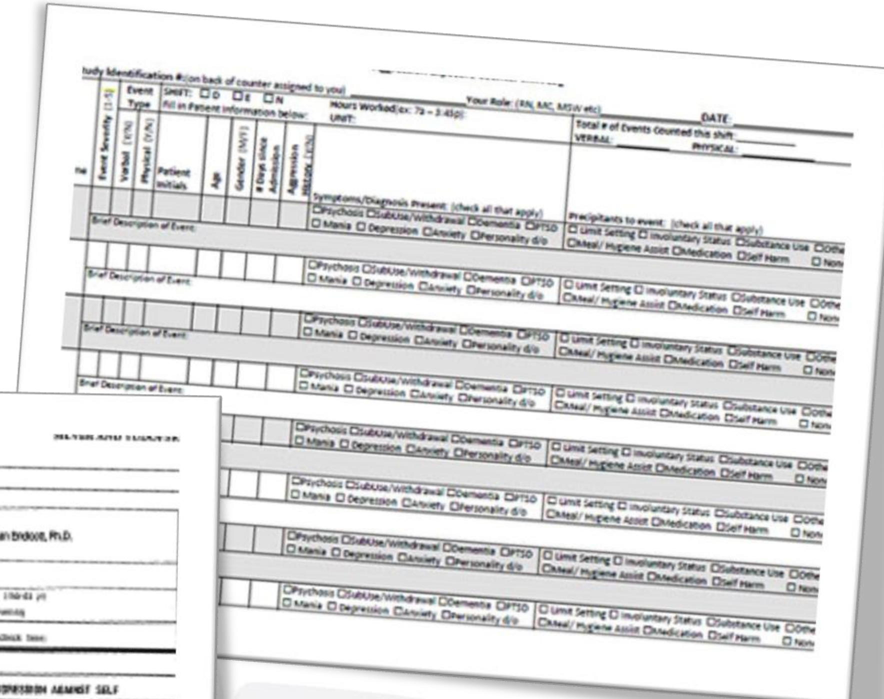
Time incident began: __ __ : __ __ am/pm — Duration of incident: __ __ : __ __ (hours/minutes)

INTERVENTION (check all that apply)

☐ None	☐ Immediate medication given by mouth	☐ Use of restraints
☐ Talking to patient	☐ Immediate medication given by injection	☐ Injury requires immediate medical treatment for patient
☐ Closer observation	☐ Isolation without seclusion (time out)	☐ Injury requires immediate treatment for other person
☐ Holding patient	☐ Seclusion	

COMMENTS

New York State Psychiatric Institute and Department of Psychiatry, College of Physicians and Surgeons, Columbia University, 722 West 168th Street, New York, NY 10032



Study Identification #: (on back of counter assigned to you) ________ Your Role: (RN, MC, MSW etc) DATE: ________

Event Type — SHIFT: ☐D ☐E ☐N — Fill in Patient information below: — Hours Worked (ex: 7a – 3:45p): — UNIT:

Total # of Events Counted this shift: ________ VERBAL: ________ PHYSICAL: ________

Event Severity (1-5)	Verbal (Y/N)	Physical (Y/N)	Patient Initials	Age	Gender (M/F)	# Days since Admission	Aggression History (Y/N)	Symptoms/Diagnosis Present: (check all that apply)	Precipitants to event: (check all that apply)
								☐Psychosis ☐SubUse/Withdrawal ☐Dementia ☐PTSD ☐Mania ☐Depression ☐Anxiety ☐Personality d/o	☐ Limit Setting ☐ Involuntary Status ☐Substance Use ☐Other ☐Meal/ Hygiene Assist ☐Medication ☐Self Harm ☐ None
Brief Description of Event:									

RASS score

Richmond Agitation & Sedation Scale				CAM-ICU
Score	**Description**			
+4	Combative	Violent, immediate danger to staff		RASS ≥ -2 Proceed to CAM-ICU assessment
+3	Very agitated	Pulls at or removes tubes, aggressive		
+2	Agitated	Frequent non-purposeful movements, fights ventilator		
+1	Restless	Anxious, apprehensive but movements not aggressive or vigorous		
0	Alert & calm			
-1	Drowsy	Not fully alert, sustained awakening to voice (eye opening & contact >10 secs)	Voice	
-2	Light sedation	Briefly awakens to voice (eye opening & contact < 10 secs)		
-3	Moderate sedation	Movement or eye-opening to voice (no eye contact)		RASS < -2 STOP Recheck later
-4	Deep sedation	No response to voice, but movement or eye opening to physical stimulation	Touch	
-5	Un-rousable	No response to voice or physical stimulation		

The NEW ENGLAND JOURNAL of MEDICINE

REVIEW ARTICLE

CRITICAL CARE MEDICINE

Sedation and Delirium in the Intensive Care Unit

Michael C. Reade, M.B., B.S., D.Phil., and Simon Finfer, M.D.

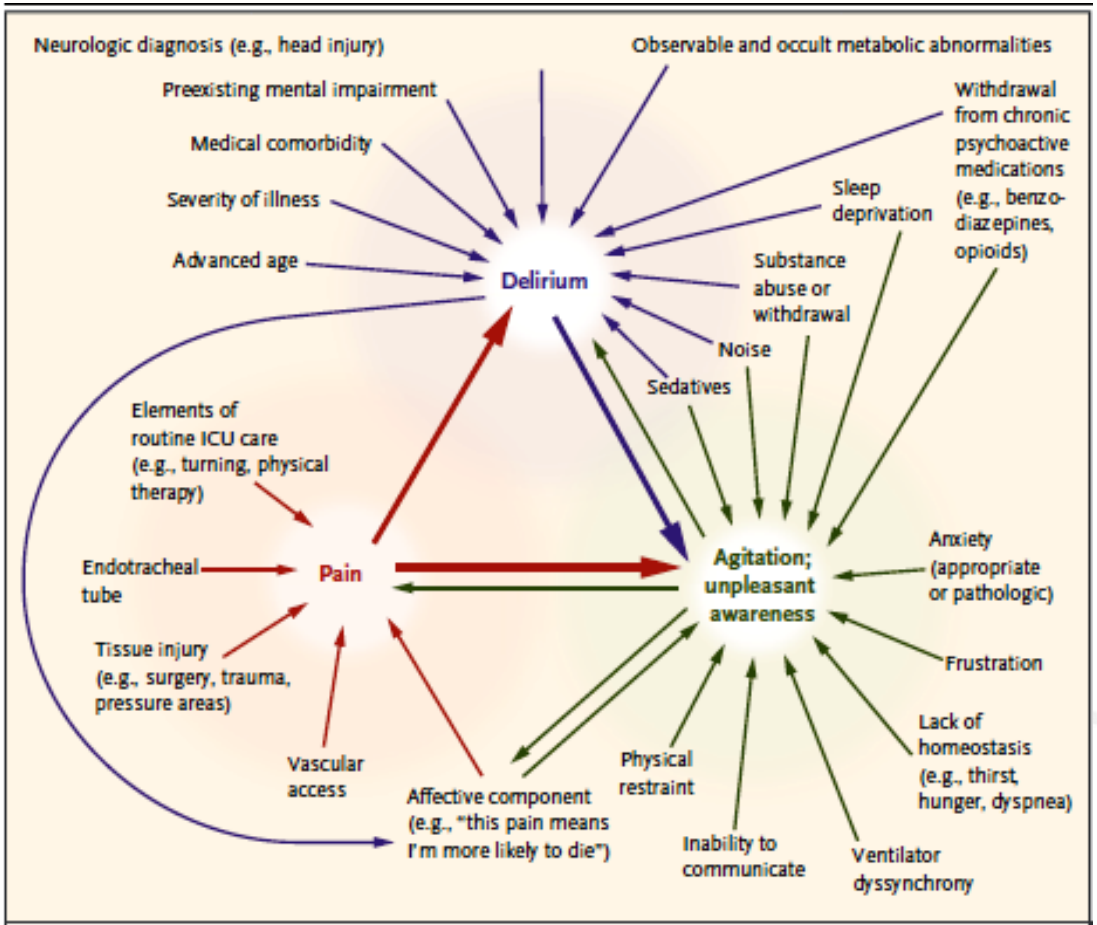


Figure 1. Causes and Interactions of Pain, Agitation, and Delirium.

Drugs and other treatments for pain, agitation, and delirium form an "ICU triad" cognitive management analogous to the "triad of anesthesia," which highlights interactions among hypnotics, analgesics, and muscle relaxants to encourage balanced anesthesia. The "ICU triad" concept highlights that changing one element is unlikely to be as effective as a coordinated approach.

N Engl J Med 2014;370:444-54.
DOI: 10.1056/NEJMra1208705

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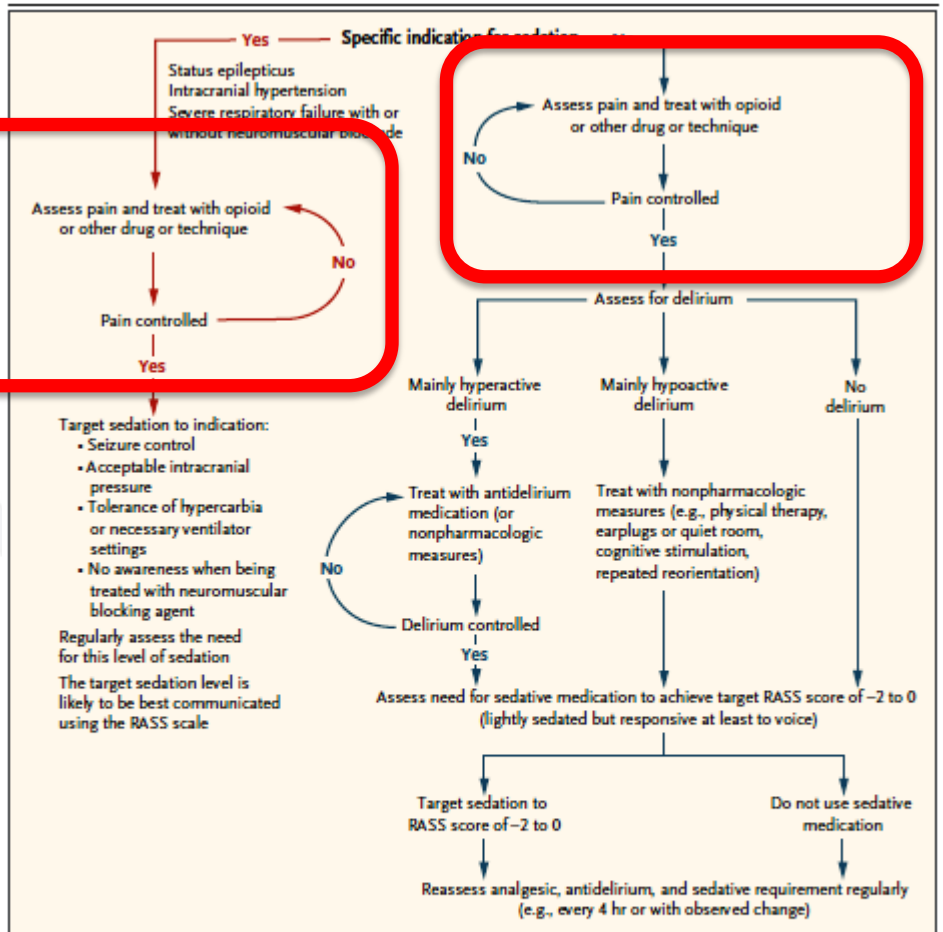

Figure 2. Algorithm for the Coordinated Management of Pain, Agitation, and Delirium.

The application of this algorithm — which combines the use of analgesics, antidelirium agents, sedatives, and nonpharmacologic techniques — will depend on the individual situation for each patient. For example, patients undergoing surgery who are suitable candidates for rapid extubation and who have little risk of delirium may be treated only with analgesia and rapidly diminishing sedation. RASS denotes Richmond Agitation–Sedation Scale, which ranges from −5 to +4, with more negative scores indicating deeper sedation and more positive scores indicating increasing agitation, and with 0 representing the appearance of calm and normal alertness.

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PATIENTS IN INTENSIVE CARE UNITS (ICUs) ARE TREATED WITH MANY INterventions (most notably endotracheal intubation and invasive mechanical ventilation) that are observed or perceived to be distressing. Pain is the most common memory patients have of their ICU stay.[1] Agitation can precipitate accidental removal of endotracheal tubes or of intravascular catheters used for monitoring or administration of life-sustaining medications. Consequently, sedatives and analgesics are among the most commonly administered drugs in ICUs.

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Safe management: Verbal de-escalation

- Certain authors have defined **10 domains of verbal de-escalation techniques** that can be used in the management of the agitated patient:[1,2]

1. Respect personal and space
2. Do not be provocative
3. Establish verbal contact
4. Be concise
5. Identify wants and feelings
6. Listen closely to what the patients is saying
7. Agree or agree to disagree
8. Lay down the law and set clear limits
9. Offer choices and optimism
10. Debrief the patient and staff

References

- Richmond JS, Berlin JS, Fishkind AB, Holloman GH, Zeller SL, Wilson MP, et al. Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalationWorkgroup. West J Emerg Med. 2012 Feb 1;13(1):11–6.
- Fishkind A. Calming agitation with words, not drugs. Curr Psychiatr. 2002;1(4).

DE-ESCALATION

- Calmi e sicuri di sé
- Muscoli facciali rilassati
- Tono di voce basso, modulato e monotono
- No simboli religiosi, politici etc.
- Non stare sulla difensiva
- Non rispondere agli insulti
- Consapevolezza sulle risorse disponibili
- Rispettosi
- Distanza >4 volte
- Non dare le spalle
- Posizione angolare
- Non fissare lo sguardo
- Non puntare l'indice
- Non sorridere
- Attenzione al contatto

Fidati del tuo istinto. Se valuti o senti che la de-escalation non sta funzionando, FERMATI!

Clinical Policy: Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department

DRAFT July 20, 2016
THIS DRAFT IS EMBARGOED

From the American College of Emergency Physicians Clinical Policies Subcommittee (Writing Committee) on the Adult Psychiatric Patient

Appendix D. Potential benefits and harms of implementing the recommendations.

1. In alert adult patients presenting to the ED with acute psychiatric symptoms, should routine laboratory tests be used to identify contributory medical conditions (non-psychiatric disorders)?

Patient Management Recommendations

Level A recommendations. None specified.

Level B recommendations. None specified.

Level C recommendations. Do not routinely order laboratory testing on patients with acute psychiatric symptoms. Use medical history, prior psychiatric diagnoses, and physician examination to guide testing.

Potential Benefit of Implementing the Recommendations: The potential benefits of implementing the proposed recommendations are both economic and affect length of stay. If testing is reduced, this would likely reduce the total cost and lengths of stay for mental health patients.

Potential Harm of Implementing the Recommendations: The potential harms for reducing routine testing is that there are certain subsets of patients who likely benefit from more laboratory testing (eg, elderly, immunosuppressed, new onset psychosis, substance use). Although not well-studied, reducing testing in these cohorts of patients has the potential for missing diseases in this population.

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2. In adult patients with new onset psychosis without focal neurologic deficit, should brain imaging be obtained acutely?

Patient Management Recommendations

Level A recommendations. None specified.

Level B recommendations. None specified.

Level C recommendations. Use individual assessment of risk factors to guide brain imaging in the ED for patients with new onset psychosis without focal neurologic deficit. (Consensus recommendation)

Potential Benefit of Implementing the Recommendations: Reducing use of diagnostic neuroimaging for patients with acute psychosis has potential benefits. The commonly used imaging tests, computed tomography (CT) and magnetic resonance imaging (MRI), are expensive. With CT, patients are exposed to ionizing radiation, with possible carcinogenic effect. Both tests require large equipment not readily available in many care settings outside of the ED, meaning that the perceived need for imaging may be a driver of patient referral to the ED. Reducing use of these tests in the evaluation of acute psychosis may enable psychiatric evaluation in more appropriate care settings such as psychiatric clinics or hospitals. Patient compliance is required for CT and MRI; agitated patients may require sedation, increasing patient risks.

Potential Harm of Implementing the Recommendations: Studies on this topic are biased and may under– or overestimate the diagnostic yield/incidence of important abnormal findings on neuroimaging. As a consequence, restricting use of diagnostic neuroimaging in new onset acute psychosis without focal neurologic abnormalities may result in missed diagnosis of important brain abnormalities requiring acute intervention, such as mass lesions, central nervous system infections, or lesions resulting in increased intracranial pressure.

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3. In adult patients presenting to the ED with suicidal ideation, can risk assessment tools in the ED identify patients who are safe for discharge?

Patient Management Recommendations

Level A recommendations. None specified.

Level B recommendations. None specified.

Level C recommendations. In patients presenting to the ED with suicidal ideation, physicians should not use currently available risk assessment tools in isolation to identify low-risk patients who are safe for discharge.

Potential Benefit of Implementing the Recommendations: The potential benefit of implementing the recommendation is a reduced rate of missing patients at risk for future suicide attempt in patients erroneously found to be at low-risk by risk assessment tools alone. Application of a highly sensitive tool would expedite safe disposition of low suicide risk cases, thereby decreasing costs, length of stay, and ED overcrowding.

Potential Harm of Implementing the Recommendations: A potential harm could be increased length of stay and unnecessary behavioral health consultations in a subset of patients who are safe for discharge.

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4. In adult patients presenting to the ED with acute agitation, can ketamine be used safely and effectively?

Patient Management Recommendations

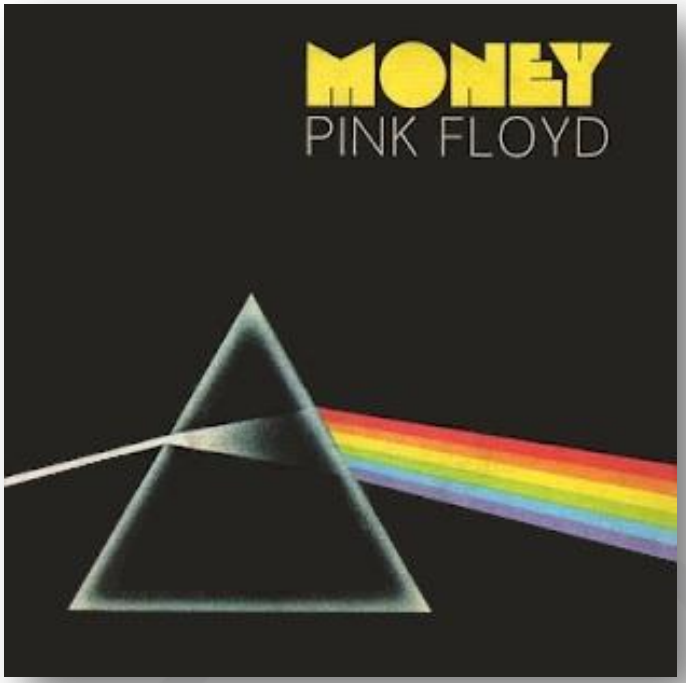
Level A recommendations. None specified.

Level B recommendations. None specified.

Level C recommendations. Ketamine is an option for immediate sedation of the severely agitated patient. (Consensus recommendation)

Potential Benefit of Implementing the Recommendations: Potential benefits of the use of ketamine in the acutely agitated patient in the ED include rapid de-escalation of the agitated patient when staff and patient safety are at risk.

Potential Harm of Implementing the Recommendations: Given the known side-effect profile of ketamine, potential harms include vomiting, laryngospasm, emergence reaction, and hypersalivation. The use of ketamine in these patients may result in a decrease in respiratory drive that requires intubation and the complications associated with ventilation support.


MONEY
PINK FLOYD

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PAIN MANAGEMENT AND SEDATION/ORIGINAL RESEARCH

Midazolam-Droperidol, Droperidol, or Olanzapine for Acute Agitation: A Randomized Clinical Trial

David McD. Taylor, MD, MPH*; Celene Y. L. Yap, MSc; Jonathan C. Knott, MBBS, PhD; Simone E. Taylor, PharmD; Georgina A. Phillips, MBBS; Jonathan Karro, MBBS; Esther W. Chan, BPharm, PhD; David C. M. Kong, BPharm, PhD; David J. Castle, MD

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in a "security code" being called for an unarmed threat. De-escalation techniques are recommended initially,[7] although parenteral medication sedation may be required.[3,5,6]

Importance

Sedation for acute agitation is required in 3 to 20 cases for every 1,000 ED presentations[3,6] and the risk to the patient is real. Adverse effects are common and include

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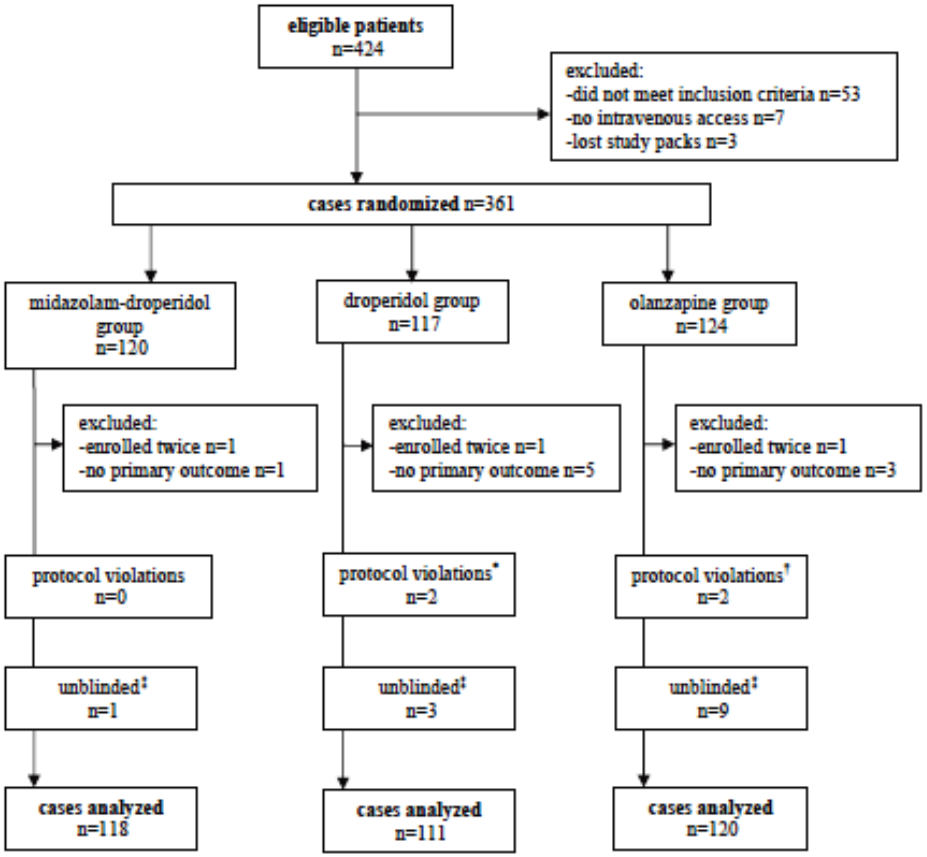

Figure 1. Patient flow through the study (modified CONSORT diagram). *Patients aged 15 and 71 years. †Patients aged 68 and 69 years. ‡Patient sedation difficult and unblinding undertaken to inform clinical decisionmaking. No unblinding was undertaken in response to adverse events.

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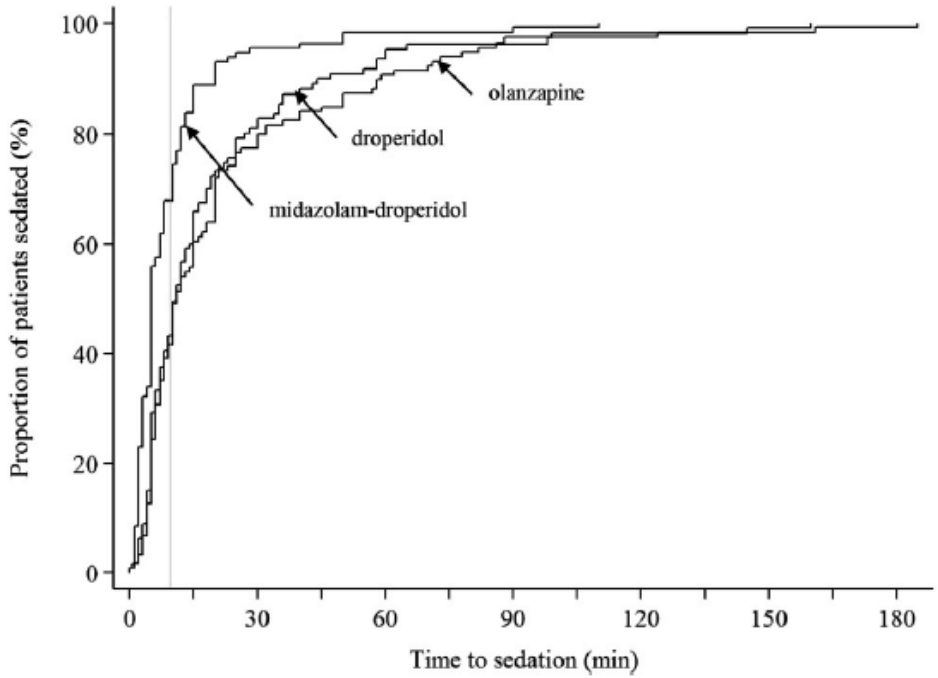

Figure 2. Kaplan-Meier curve comparing the proportion of patients sedated as a function of time. The vertical line is at 10 minutes, with the proportion sedated at the time of the primary outcome of the study.

ORIGINAL RESEARCH

Prehospital Use of IM Ketamine for Sedation of Violent and Agitated Patients

Kenneth A. Scheppke, MD[*]
Joao Braghiroli, MD[†]
Mostafa Shalaby, MD[‡]
Robert Chait, MD[§]

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METHODS

We retrospectively screened paramedic run sheets from January 1, 2011 through May 1, 2014 for cases where the ketamine protocol was used for complaints of violent, aggressive behavior secondary to a psychiatric or substance-abuse issue. Reviewing the run sheets generated from these encounters we (R.C.) investigated the apparent benefits and risks of intramuscular ketamine given to sedate violent and agitated patients in the field. Approval from the university Institutional Research Board was obtained to review those records.

The medical director of several municipal fire/rescue agencies in Palm Beach County Florida (Boynton Beach Fire Rescue, Palm Beach Gardens Fire Rescue, Greenacres Fire Rescue, Town of Palm Beach Fire Rescue, and West Palm Beach Fire Rescue) has the authority and responsibility to develop medically correct standing orders for paramedics to use while treating patients in the prehospital setting.[2]

Under this authority, and in response to continuous feedback from paramedic crews about the difficulty and lack of success in dealing with and subsequently treating patients with violent or agitated behavior, a protocol was developed to allow rapid chemical restraint of these patients (including suspected ExDS) through the use of ketamine given as a single intramuscular injection at a dose of 4mg/kg of estimated body weight (Figure).

After initial sedation and control of the patient with ketamine, and per protocol, if possible, an intravenous line was established and a recommended dose of 2.0-2.5mgs of midazolam was given to prevent the well known but infrequent occurrence of a ketamine-induced emergence reaction.[3] Following appropriate chemical restraint, treatment of the underlying medical problem was to be initiated in the standard manner and the patient was transported to the closest appropriate hospital per protocol. We obtained cases where use of the ketamine sedation protocol occured from the above noted fire/rescue agencies from January 1, 2011 through May 1, 2014 and reviewed these reports. As a matter of routine paramedic practice, several sets of vital signs were obtained during transport, and any adverse hemodynamic or respiratory effect of the ketamine was noted on the paramedic run sheet.

ORIGINAL RESEARCH

Prehospital Use of IM Ketamine for Sedation of Violent and Agitated Patients

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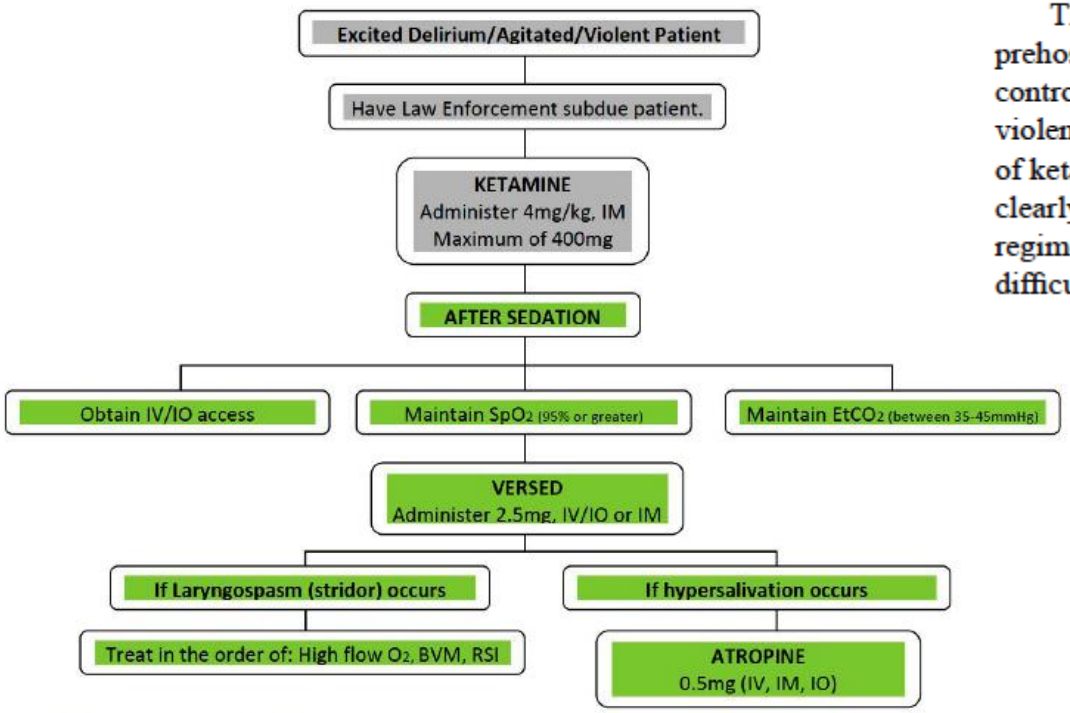

Figure. Prehospital ketamine protocol flowchart.
IM, intramuscular; *IV*, intravenous; *IO*, intraosseous infusion; *EtCO*$_2$, end tidal CO$_2$; *BVM*, bag-valve-mask; *RSI*, rapid sequence intubation

CONCLUSION

This study demonstrates that IM ketamine in the prehospital setting is a good choice to gain rapid medical control of patients with potential ExDs and those exhibiting violent and agitated behavior. A prospective head-to-head trial of ketamine versus other drugs should be carried out with clearly defined endpoints to fully delineate which therapeutic regimen is best for the rapid sedation and control of this difficult-to-manage patient population.

Prehospital Ketamine is a Safe and Effective Treatment for Excited Delirium in a Community Hospital Based EMS System

Thomas R. Scaggs, MD;[1] David M. Glass, MD;[2] Megan Gleason Hutchcraft, MD;[3] William B. Weir, MD, FAAEM, FACEP[1]

Scaggs Scale
+4 Excited Delirium
+3 Extremely Agitated
+2 Moderately Agitated
+1 Restless
0 Calm, Oriented, Alert
–1 Drowsy
–2 Light Sedation
–3 Moderate Sedation
–4 Deep Sedation

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Table 3. Scaggs Scale

Sedation of the Extremely Agitated Patient
Primary consideration should be given to EMS provider safety.
Notify police. Approach patient only when safe to do so.
Talk in an even, reassuring tone; only one provider should speak.
Restrain as needed if patient is a threat to self or others.
CRITERIA (Any may be present)
Extreme psychological and physiological excitement/agitation.
Aggressive or hostile combative behavior marked by incoherence.
Superhuman strength with near complete tolerance to pain.
Impaired thinking and perception; paranoia.
Relative inability to "talk down."
TREATMENT
#1: Initial Medical Care. Sedate patient as necessary (as per #5 or #6 below) based on patient's presentation and potential for self-harm. Contact medical control prior to sedation if questions/concerns exist regarding care.
#2: Airway and OXYGEN 15 L NRB.
#3: Assessment and history:
Look for medical or traumatic causes of the patient's behavior.
Note (and later document) behavior and mental status in detail.
Obtain medical history; alcohol and psychiatric history, if able.
#4: IV of NS or saline lock, if able.
#5: Administer KETAMINE 5 mg/kg IM or 1.5 mg/kg IV.
#6: Alternative chemical sedative: MIDAZOLAM 0.05 mg/kg IV Q3-5 minutes up to a total of 3 doses as needed or maximum 10 mg.

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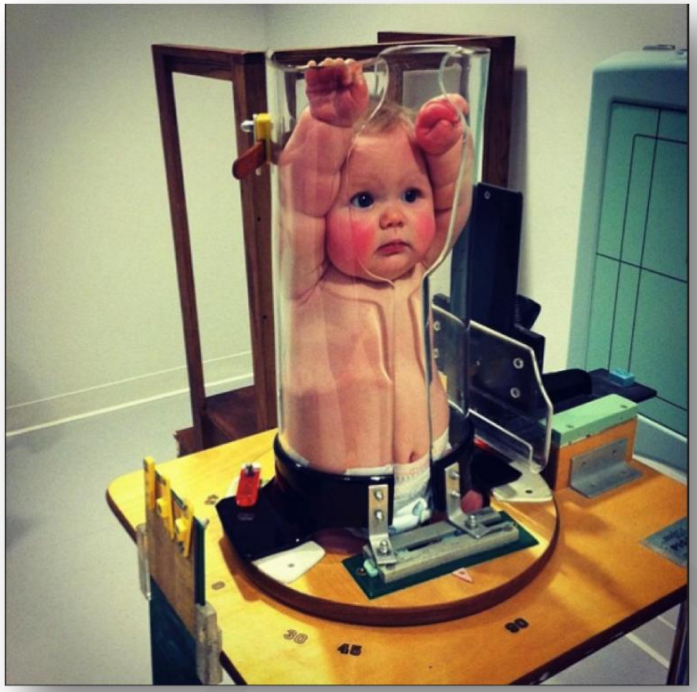
Table 1. Sedation of the Extremely Agitated Patient
Abbreviations: EMS, Emergency Medical Services; IM, intramuscular; IV, intravenous.

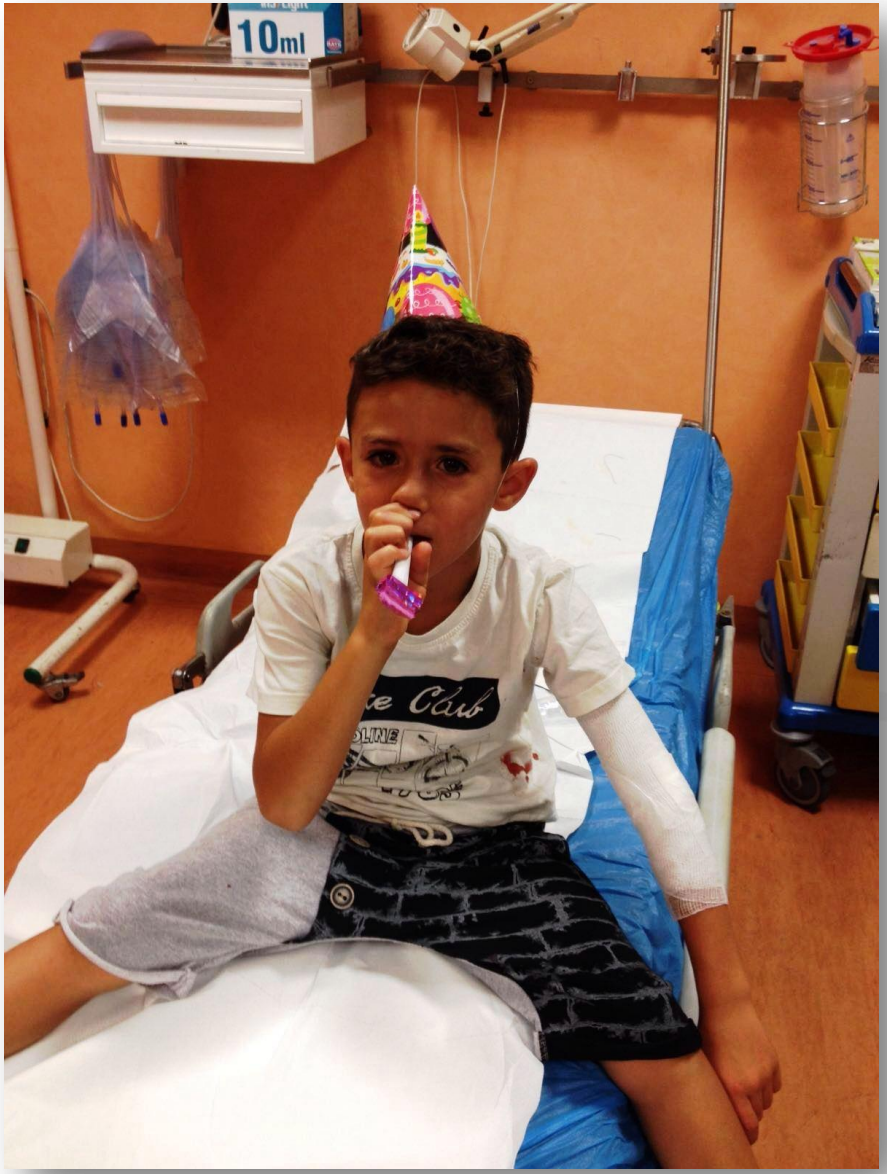
Conclusion

It was demonstrated that ketamine administered by paramedics in the prehospital setting is a safe and effective treatment for ExDS. Ketamine may very well be the most effective, reliable, and safe sedative with rapid onset and should be considered first line treatment for ExDS.

http://dx.doi.org/10.1017/S1049023X16000662

...e i bambini?



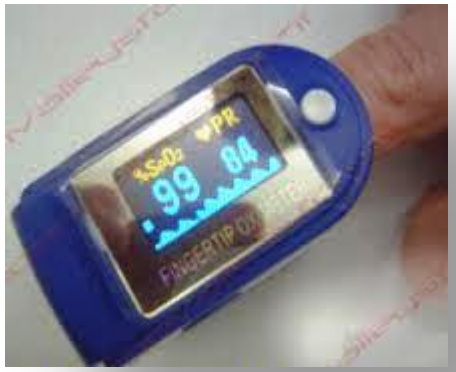

10ml

...dove eravamo rimasti?

AGITATED PATIENT MANAGEMENT IN EMERGENCY DEPARTEMENT

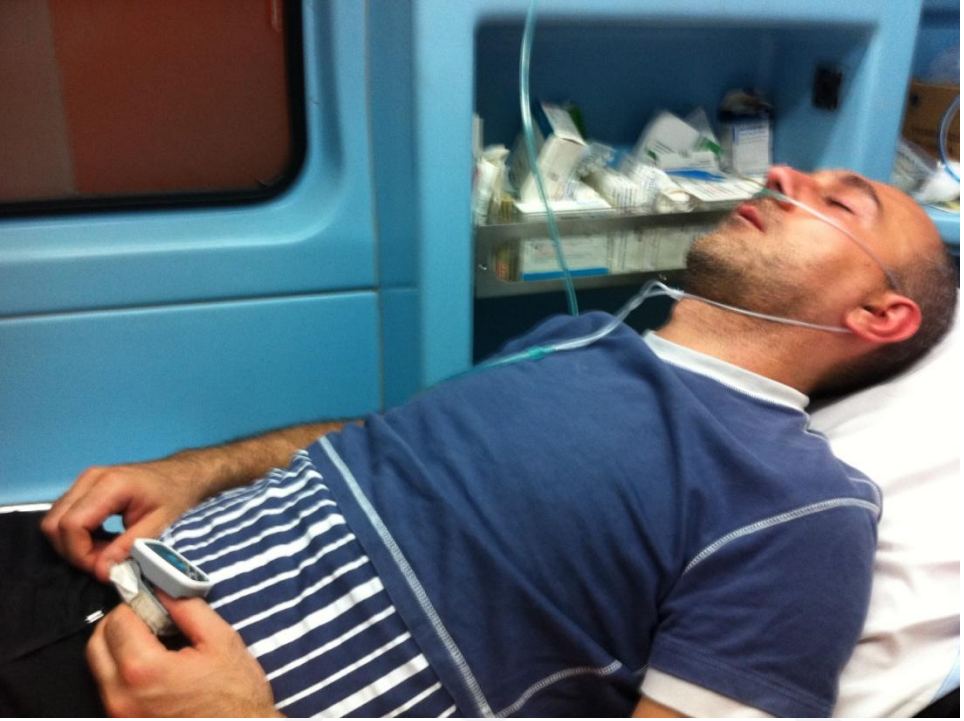
Idea!

"Nunzio ma tu respiri male, hai fumato 99 sigarette è scritto qua!
"Ehhh Duttò pure 'e cchiù"



"Devi fare un po' di aerosol con la siringhina e…"

- **MIDAZOLAM 60 MG I.N.**
- **MONITORAGGIO**
- **RAMSAY 4**




GLI AMMALATI SONO
FIGURA DI CRISTO.
IL DOLORE NON È UNA
CONTRATTURA MUSCOLARE
MA IL GRIDO DI UN'ANIMA.
SAN GIUSEPPE MOSCATI

...cos'è la vita?

A me lo ha insegnato Salvatore!

Ma i medici d'urgenza non sono pazzi?!

Io sono pazzo
e voglio essere chi voglio io.
Uscite fuori da casa mia,
ho il popolo che mi aspetta
e scusate vado di fretta.
Non mi date sempre ragione,
Io lo so che sono un errore
Ma nella vita voglio vivere almeno un giorno da leone.
E lo Stato questa volta non mi deve condannare,
perché sono pazzo, ed oggi voglio parlare.
Se mi arrabbio metto tutti faccia al muro.
E non sono menomato,
sono pure diplomato
e la faccia nera l'ho dipinta
per essere lodato!

Je so' pazzo je so' pazzo
e vogl'essere chi vogl'io
ascite fora d'a casa mia
je so' pazzo je so' pazzo
ho il popolo che mi aspetta
e scusate vado di fretta
non mi date sempre ragione
io lo so che sono un errore
nella vita voglio vivere
almeno un giorno da leone
e lo Stato questa volta
non mi deve condannare
pecchè so' pazzo je so' pazzo
ed oggi voglio parlare.
Je so' pazzo je so' pazzo
si se 'ntosta 'a nervatura
metto a tutti 'nfaccia o muro
je so' pazzo je so' pazzo
e chi dice che Masaniello
poi negro non sia più bello?
e non sono menomato
sono pure diplomato
e la faccia nera l'ho dipinta
per essere notato
Masaniello è crisciuto
Masaniello è turnato
je so' pazzo je so' pazzo
nun nce scassate …