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Don’t Miss the Forest for the Trees: The Challenge of Accurately Identifying the Signs and Symptoms of Agitation in Emergency Settings

Announcer:
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Dr. Wilson:
Hi. I'm Dr. Sharlena Wilson. And I'm a psychiatric position and currently the Vice Chair of the Department of Psychiatry at Providence Little Company of Mary Medical Center in San Pedro. Today we will be talking about agitation and the title of our presentation is Don’t Miss the Forest for the Trees: The Challenge of Accurately Identifying the Signs and Symptoms of Agitation in Emergency Settings.

There are some guidelines called the Six Goals of Emergency Psychiatric Care that were set forth by a colleague of mine, Dr. Zeller, and some other experts in the topic about how to approach a patient with acute agitation.

So the first of these goals is to exclude medical etiologies for symptoms to ensure medical stability. Prematurely attributing agitation to psychiatric illness could potentially cause the clinician to miss life-threatening illness or injury. And you should also remember that patients with psychiatric illness also have medical comorbidities that might actually exacerbate their psychiatric illness. So we want to make sure that we're paying attention for those as well.

So as clinicians, the first thing that we want to do when we are examining a patient presenting with agitation is to perform an H&P. So admittedly, this can be a little bit difficult with patients who have agitation. And the first thing that we want to do is ensure the safety of patient and staff. So you want to find a calm, private, but not isolated setting, and free of anything that can be used as a weapon. We want to use nonconfrontational tone and body language, and watch for signs of escalation, such as tense posturing or increased speech volume. You want to then gather as much information as possible regarding the patient while staying within their level of tolerance. So if they're already a little agitated, we have to be mindful of that and not push too hard.

We also want to gather as much information from collateral sources as possible. So if there's a family member there with the patient, or the EMT that brought the patient in, then they can have extra information from the scene.

We also then want to make sure we’re performing vitals and physical exam. Vitals can be especially important. When someone's presenting with agitation, you would expect for their heart rate to be elevated, maybe even their blood pressure would be a little bit high. But if you're seeing things that are a bit odd, such as low oxygen saturation or fever, then that can clue you in that something medical is going on.

Now, one of the main things that we're looking for when differentiating between a medical cause of agitation versus a psychiatric, is delirium. So delirium saw a specific diagnosis, but rather a constellation of symptoms of cerebral dysfunction common to patients suffering from various potentially life-threatening medical conditions. It does sometimes mimic psychiatric illness, but there are a few characteristics that can fill you in that this might be acute delirium. Those include fluctuating levels of consciousness, major disturbance

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in attention, and disorientation and memory impairment.

So the differential diagnosis for delirium or other causes of acute agitation is very long, so I won't go through the whole list. But as you can see, it can be toxicological, it could be metabolic, neurologic, or psychiatric. So these are the things that you have to have in your mind as you narrow down your differential.

So with all that being said, the main thing is to remember the agitation is always part of a bigger picture. You're always looking for agitation, and something else that will clue you into what the cause of the agitation is. So there's agitation and a history of Schizophrenia or Bipolar Disorder, and a collateral source like a family member telling you a patient stopped taking their medication 5 days ago, and since then, has been increasingly agitated, then that would probably lead you more so in the direction that this is a psychiatric cause.

Well, let's look at some other possible causes. For example, delirium tremens from alcohol withdrawal. So they might present with agitation and disorientation, as well as hallucinations and some tachycardia, but you also would notably have tremulousness, and you will find an alcohol abuse history.

Looking at thyroid storm, again, you'd have agitation and disorientation, possibly even hallucinations, but you'd see fever and diaphoresis, as well as tachycardia, tachypnea, and possibly a hyperthyroidism history.

Another one is hyponatremia, which again, you see agitation disorientation, but you might also see unsteady gait and a history of acutely increased water intake. So one of the reasons I bring this up is because this could be due to psychogenic polydipsia, in which case the patient may have history of Schizophrenia, but they might also be drinking a lot more water than usual, leading to hyponatremia and the presenting symptoms.

What I also want to look at is akathisia. So akathisia can present with agitation and anxiety, and notably, a lot of restlessness. These patients just keep moving and keep moving. So these patients might have a history of Schizophrenia or Bipolar Disorder, but what you might also note in their history is a recent change in medication or increase in antipsychotic medication, which would cause the side effect of akathisia, rather than the agitation being primarily from the Schizophrenia or Bipolar Disorder itself.

And a few last considerations, maybe a few clinical pearls that might help you out a bit, is paying attention to hallucination types. In Schizophrenia or Bipolar Disorder, the most common type of hallucination is auditory, and visual are also common. If you have a patient presenting with tactile hallucinations, you might want to consider stimulant intoxication, in which case, they oftentimes will complain a feeling like something is crawling on their skin, and they might be picking at things.

If you have a patient that's presenting olfactory hallucinations, which are quite rare, that's typically more common in neurologic illness. So you would want to have a good neuro examine and workup.

Another special consideration is age, the peak onset for both Schizophrenia and Bipolar Disorder tends to be in the 20s and 30s. So if you're seeing anyone presenting with first-time agitation at any of the extremes of age, then you might want to consider a wider differential. This is especially true in our elderly population, in which case, things as simple as a UTI could cause delirium. So you want to make sure that you're getting a good exam and workup on that population.

And another special population to consider is victims or survivors of trauma. Patients who are victims of intimate partner abuse, or who are victims of human trafficking, may present in an emergency setting and be very anxious and seem paranoid. But it may not be a delusional paranoia, they may actually be afraid of their perpetrator, who may even be with them. So watching for cues that there might be something in a patient's social situation that are causing fear or agitation that is very real, and something to definitely be able to look out for.

And then lastly, hospital settings may trigger memories for patients who may have had not so great experiences in hospitals before. So being mindful of that and making sure that you are being reassuring for your patient and letting them know that you are there to help them can go a long way in working with that patient to get a history and figure out what is causing their agitation.

Thank you so much for joining me on this talk about diagnosing agitation in emergency settings, and I hope it was helpful

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