CASE REPORT

MANAGING AGGRESSIVE PATIENTS - WEST PARK HOSPITAL EXPERIENCE: A CASE REPORT

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Abstract

Objective: **Newly qualified doctors on the wards are sometimes faced with difficult situations and difficult patients on the wards. We report a case and provide insight into management of these patients.** ***Methods:*** **This was only second week into the job. This patient was admitted to psychiatry ward from medical assessment unit because of acute episode of psychosis.** ***Results:*** **The patient was given some medications along with physical restraint. He was first given haloperidol and then lorazepam. He settled after these medications. He was thoroughly assessed by a multidisciplinary team headed by the consultant next day. He was diagnosed as brief psychotic disorder. He stayed on the unit for some time and was then discharged home on regular antipsychotic. He was booked into 1 monthly clinic and was given community support as well.** ***Conclusion:*** **Aggression can happen for a variety of reasons, i.e. acute psychosis and mania. Management varies according to the diagnoses. Physical restraint and medications form an essential part of management. However it is of utmost important to rule out medical causes of aggression. Substance abuse is the most common cause of aggression in developed countries.** ***ASEAN Journal of Psychiatry, Vol. 13 (1), January - June 2012: XX XX.***

Introduction

This article is aimed at helping junior doctors develop a structured approach towards managing these patients. It looks at organic and non organic causes and how they should be managed. We have discussed two important drugs i.e. lorazepam and haloperidol in detail. Sometimes after giving these medications, patient can develop serious side effects which may cause anxiety among junior officers. In this article we briefly touched on how to manage these complications.

Case Report

A 65 years old male was admitted to the acute assessment unit of a medical ward with an episode of confusion and strange behavior. He was reported to be having delusions for the last 2 days at home. On the medical ward he had baseline investigations to look for the cause of the confusion. This included detailed physical examination, infection markers, electrolytes, drug levels and a chest-X-ray. All of the results were normal. He was then referred to the psychiatric team. Mental state exam was performed by a junior psychiatric doctor and found to be delusional. He was taken to a psychiatric ward for continuing care and diagnosed as suffering from acute psychotic disorder. Detailed history on psychiatric ward revealed positive history of schizophrenia in patient's parents but nothing else in history was

significant. He was started on quetiapine and put under close observation. Forty-eight hours into admission to psychiatry ward; he became very aggressive on one of my shifts. A registrar was consulted and advised us to give a dose of parenteral haloperidol and reassess him after some time. He had to be physically restrained and needed a dose of lorazepam on top of haloperidol which was given. The combination eventually calmed him down. He was closely observed for the rest of the night by ward staff. Fortunately there was no further mishap. His final diagnosis was brief psychotic disorder and after a stay of 3 months on the psychiatry unit, he was discharged home on optimized doses of antipsychotic. Follow-up was arranged and community support was put in place.

Discussion

Aggression in humans describes a variety of human behaviors i.e. verbal aggression, being physically aggressive to humans or animals and physical aggression against objects. The other term commonly used is violence which is denoted by one person's physical aggression against another human. Causes of aggressive behaviour include medical, substance abuse (intoxication and withdrawal), dementia, personality disorder (antisocial) and psychiatric causes. Some common medical causes in aggressive patients are brain injuries, brain tumor, metabolic disturbance and epilepsy. Important psychiatric causes are schizophrenia, mood disorders and anxiety disorder [1].

It is important to assess the patient systematically. Three steps are very useful for structured assessment. First is taking history about the person's past and current behavior from care, family, friends and patient's doctor. Second is evaluating past treatment of the patient whether it was successful or not. Last but not the least is physical examination of the patient to look for any medical cause i.e. pain, infection, self harm or injury. In a patient with acute agitation with unknown history, it is important to rule out medical emergency like delirium which is a reversible condition of confusion and sometimes aggression, due to a medical cause [2]. In this situation, it is necessary to mechanically restrain a patient from self-harm. Once an acute episode in managed, strategies are devised to prevent or reduce the intensity of such episode in future. Next is physical examination along with abbreviated mental state examination mostly used in acute hospital settings by asking 10 questions. Aggressive behavior in a ward may be caused by crowding and, nursing staff showing commanding behavior or under involvement of medical staff with regard to ward activities. Patients may be vulnerable in a particular period of the day, peak problem period of 7:00-9:00 am. Patients who are briefly violent show better response to typical neuroleptic medication. They have less neurological impairment than persistently aggressive people.

Patients with medical conditions are not normally known to be violent. Head injuries, brain tumors, metabolic conditions and epileptic patients can show aggressive behavior due to neurohumoral mechanisms. Physical assessments involving laboratory and imaging investigations should be used to diagnose and manage these conditions.

Alcohol, cocaine, phencyclidine (PCP), or amphetamine intoxication is the common substances of misuse guilty of causing aggression. Water, caffeine, antihistamines and aerosols intoxication in the inpatient settings are important to consider. Withdrawal from substances can also lead to aggressive behavior. Management should be done by specific treatment for the substance of misuse and involving social services along with psychiatric input. Schizophrenic patients are mostly not aggressive [3]. Their aggressiveness is the result of noncompliance with medications. A hint to diagnosis is worsening of psychotic symptoms. In recent studies, 24-44% of aggressive acts committed with schizophrenics occur during an acute phase of the illness. Neuroleptic blood levels have been found to be inversely connected with violent/aggressive actions in these patients. Patients need to be treated by psychiatrists by augmenting a particular treatment, introducing a new treatment or reducing some drug therapy. Unfortunately dementia patients have poor impulse control. Cognitive impairment for more

than 6 months and assessment of memory functions establishes the diagnosis. These patients are best treated in psychiatric settings. In antisocial people, intimidation of staff or patients and material gain activities may be factors in antisocial personalities. These patients along with mood disorder patients should be referred for psychiatric assessment and management.

Treatment can be discussed under 2 headings. This includes non-pharmacological treatment and pharmacological considerations.
Non-pharmacological treatment revolves around some basic principles [4]. Firstly look for possible environmental hazards. (e.g., objects that can be thrown or used as a weapon). Then evaluate physical conduct of the patient (e.g., patients point towards staff or other patients make a fist before punching or kicking). All staff must be aware where the patient is at all times (e.g., do not turn your back to the patient; do not leave the patient alone and therefore unobserved). Verbal threats should be taken seriously. One should distance several feet away to avoid crowding the patient. Calm, confident, competent demeanor is vital for successful de-escalation. De-escalation can be done by engaging the patient in conversation. We must avoid arguments between staff members in front of the patient. At least 4 people should be available if there is a need for restraint.

Some of the drugs used for treating aggressive patients are lorazepam, haloperidol, olanzapine, zuclopenthixol, risperidone, quetiapine, lithium, sodium valproate and beta-blockers. Before starting treatment consider the type of aggressive behavior presentation i.e. if a patient is aggressive due to a psychotic illness, it is recommended to start the patient on antipsychotic treatment and then commence on a tranquilizer like lorazepam. The other thing is to start from a lower dose towards a higher dose and giving appropriate intervals between medications to give that particular medication time to settle in the system [5].

LORAZEPAM	***HALOPERIDOL***
Indications, Acute aggression of unknown etiology	Indication Aggression on a background of psychotic symptoms
Peak-concentration Oral-2 hours IM-60 to 90 minutes	Peak-concentration Oral-2 to 6 hours IM-15 to 60 minutes
Side-effects Ataxia, Nausea, Vomiting Rebound insomnia	Side-effects Extra-pyramidal side-effects, dystonia, stiffness, dry mouth, constipation, blurred vision
Caution Respiratory depression Reduced conscious level	Caution Neuroleptic malignant syndrome(increased temperature, body stiffness, respiratory depression)
Dose Oral 1-2 mg, Max Dose-4mg IM= 1-2mg	Oral 3-5 mg, Max dose-30 mg IM 3-5 mg, Max dose-18 mg

The medications mentioned other than these 2 should only be used with psychiatric advice preferably in a psychiatric setting.

Remedial measures in rapid tranquilisation

PROBLEM	REMEDIAL MEASURE
Acute dystonia Acute laryngeal dystonia	Give procyclidine 5-10 mg IM or IV Administer oxygen, administer 5-10 mg IM or IV procyclidine, call emergency medical team
Reduced respiratory rate i.e. <10/min or Oxygen saturations, 90 %	Give Flumazenil if benzodiazepine induced respiratory depression. Flumazenil should be given 200 micrograms IV over 15 seconds then 100 micrograms every 60 seconds as required. Usual dose 300-600 micrograms. Maximum dose is 1 milligram
Irregular or slow pulse <50/minute	Immediate ECG, cardiac monitoring, blood pressure monitoring
Fall in blood pressure. Diastolic <50 mmHg	Lie patient flat, tilt bed towards head or raise legs Fluid resuscitation
Increased temperature	Withhold antipsychotic until creatinine level is checked. Keep patient cool and seek further medical advice

Successful management of aggressive behavior revolves around treatment of underlying cause. Careful assessment, leading to a correct diagnosis, prompts treatment selection. Non-pharmacological management is vital for patients as well as staff safety. Pharmacological treatment mostly involves lorazepam for aggression due to unknown disorder whereas haloperidol is widely used for aggressive patients with psychotic disease. Mood stabilizers, such as lithium or valproate are also used in patients with schizophrenia, typically as adjuncts to antipsychotic treatment to decrease the intensity and frequency of agitation and poor impulse control. However, they have not been studied extensively under double-blinded placebo-controlled conditions. Delirium is a medical emergency and it needs aggressive treatment .It is important to keep in mind that psychiatric input for current as well as future management is part of the plan of treatment for these patients.

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