Be aware: Sudden discontinuation of a psychotropic risks a lethal outcome

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For mentally ill young men, especially, abruptly stopping a psychotropic medication can be lethal.[1] Under such circumstances, *excited delirium syndrome* (EDS), also known as *sudden in-custody death syndrome* and *Bell's mania*, can occur, warranting your careful observation.

Approximately 10% of EDS cases are fatal[2]; >95% of fatalities occur in men (mean age, 36 years).[3] Most cases involve stimulant abuse—usually cocaine, although cases associated with methamphetamine, phencyclidine, and LSD have been reported. Patients who present with EDS experience a characteristic loss of the dopamine transporter in the striatum and excessive dopamine stimulation in the striatum.

What should you watch for?

Other syndromes and disorders can mimic EDS (***Table***), but there are certain specific symptoms to look for. Patients who have EDS can present with delirium and an excited or agitated state. Other common symptoms include:

- altered sensorium
- aggressive, agitated behavior
- "superhuman" strength (including a tendency to break glass or unwillingness to yield to overwhelming force)
- diaphoresis
- hyperthermia
- attraction to light.

Patients who have EDS often exhibit constant physical movement. They are likely to be naked or inadequately clothed; to sweat profusely; and to make unintelligible, animal-like noises. They are insensitive to extreme pain.

Table

Differential diagnosis of excited delirium syndrome

Acute paranoid schizophrenia
Bipolar disorder
Diabetic hypoglycemic reactions
Emotional rage from acute stressful social circumstances
Heat stroke
Neuroleptic malignant syndrome
Psychotropic medication withdrawal or nonadherence
Serotonin syndrome
Thyrotoxicosis

In a small percentage of cases, EDS progresses to sudden cardiopulmonary arrest and death.[3]

Medication or restraints?

Many clinicians consider aggressive chemical sedation the first-line intervention for EDS[2,3]; choice of medication varies from practice to practice. Restraints often are necessary to ensure the safety of patient and staff, but use them only in conjunction with aggressive chemical sedation. Physical struggle is a greater contributor to catecholamine surge and metabolic acidosis than other types of exertion; methods of physical control should therefore minimize the time a patient spends struggling while safely achieving physical control.

What is the treatment for EDS?

Begin treatment while you are evaluating the patient for precipitating causes or additional pathology. There are cases of death

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from EDS even with minimal restraint (such as handcuffs),[1,2] without the use of an electronic control device or so-called hog-tie restraint.

When providing pharmacotherapy for EDS, consider a benzodiazepine (midazolam, lorazepam, diazepam), an antipsychotic (haloperidol, droperidol, ziprasidone, olanzapine), or ketamine.[4] Because these agents can have depressive respiratory and cardiovascular effects, continuously monitor heart and lungs.

Many clinicians consider chemical sedation the first-line intervention for EDS

References

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