

ORIGINAL ARTICLE

Pharmacological management of agitation in emergency settings

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Objective: To review, firstly, published studies comparing classic antipsychotics, benzodiazepines, and/or combination of both; and secondly, available data on the use of atypical antipsychotic medications in controlling agitation and aggressive behaviour seen in psychiatric patients in emergency.

Method: In the first review, studies comparing antipsychotics, benzodiazepines, and combination of both; and in the second review, efficacy trials of atypical antipsychotics that include an active and/or inactive comparator for the treatment of acute agitation were identified and reviewed. Data from clinical trials meeting the inclusion criteria were summarised by recording improvement rates, definition of improvement, and timing of defined improvement for individual studies.

Results: In the first review, 11 trials were identified meeting the inclusion criteria, eight with a blind design. The total number of subjects was 701. These studies taken together suggest that combination treatment may be superior to the either agent alone with higher improvement rates and lower incidence of extrapyramidal side effects. In the review of atypical antipsychotic agents as acute antiagitation compounds, five studies were identified, three with a blind design. The total number of subjects was 711, of which 15% (104) was assigned to the placebo arm. This review found atypical antipsychotics to be as effective as the classic ones and more advantageous in many aspects.

Conclusion: Atypical antipsychotics such as risperidone, ziprasidone, and olanzapine with or without benzodiazepines should be considered first in the treatment of acute agitation. If these agents are not available the combination of a classic antipsychotic and a benzodiazepine would be a reasonable alternative. An oral treatment should always be offered first for building up an alliance with the patient and suggesting an internal rather than external locus of control.

Agitation is a non-specific constellation of comparatively unrelated behaviours that possess a risk to the safety of the patient or caregiver, impedes the process of care giving or impairs a person's function.^{1,2} Representing a state of poorly organised and aimless psychomotor activity stemming from physical or mental unease; agitation, can be seen in a variety of clinical situations, such as; delirium, dementia, psychoactive substance intoxication and withdrawal, schizophrenia, delusional disorder, psychotic disorder NOS, bipolar disorder, major depressive disorder, anxiety disorder, acute reaction to stress, post-traumatic stress disorder, antisocial/borderline/paranoid personality disorder, autism, mental retardation, attention deficit hyperactivity disorder, conduct disorder, and akathisia.^{1,3} Given the diversity of clinical entities from which agitation may arise it is not surprising that it is among the most commonly encountered clinical problems in psychiatric facilities and hospital emergency services. However, quite surprisingly this area has received such little attention and has not been a target for clinical trials until recently. Thus, tremendous variability exists in approach to agitation, both across geographical regions and across providers within regions.⁴

During the past decade or so classic antipsychotics and benzodiazepines have been used to control agitation/aggression first as monotherapy and then in combination as a result of some potentially serious adverse effects of these agents.^{5–14} While, the question of best clinical practice among the classic antipsychotics versus benzodiazepines versus combination of both waits for an answer, atypical antipsychotics have been introduced recently. Stemming from the observations based on a longer term use, a few investigators have investigated the usefulness of atypical antipsychotics specifically in the first a few hours of treatment of agitated patients.¹⁵ Although, data coming from these initial trials are

quite encouraging, the use of atypical antipsychotics in emergency services before the use of traditional antipsychotics like haloperidol needs to be incorporated into the service guidelines in emergency settings. This may in part relate to the unfortunate clinical impression that these novel drugs may not be very effective in the acutely agitated and psychotic patient and intramuscular route of administration is an absolute necessity in such emergency situations.¹⁶ Indeed, in many settings, intramuscular medications are first line treatment for agitation with or without psychosis and intramuscular formulations of the novel agents are yet to be available for common use.¹⁶ Unfortunately, an emergency practice over-reliance on classic intramuscular antipsychotics without evidence of necessity, not only puts these patients with psychotic disorders who require emergency intramuscular treatment still at risk of adverse effects of these agents during critical phases of their illness, but also delays the start of treatment with novel antipsychotics with superior efficacy and safety profile.¹⁷

Originating from an unmet clinical need on the management of agitation in emergency situations, this article has three objectives: (1) To examine published studies comparing conventional antipsychotics, benzodiazepines, and/or combination of both to achieve calm in acutely agitated psychiatric patients. (2) To review available data on the use of atypical antipsychotic medications for acute treatment of agitation associated with psychiatric illness. (3) To present an evidence based discussion on the route of administration of anti-agitation treatment.

METHOD

A computer assisted literature search of the National Library of Medicine's Medline has been completed with the use of

Table 1 Demographic and diagnostic features of the studies comparing benzodiazepines, classic antipsychotics, and the combination of both in the treatment of acute agitation

Source/year	Mean baseline agitation score SD			Assessment scale	Sample size male/female			Age mean ^a -median ^b SD ^c /range ^d			Final diagnostic impression (in the order of frequency)
	Comb	CI Aps	Benz		Comb	CI Aps	Benz	Comb	CI Aps	Benz	
Battaglia/1997	49* Not stated	46.7* Not stated	50.6* Not stated	BPRS (11 selected item)	25/7	25/10	23/8	34.4 ^a 18-54 ^d	34.3 ^a 18-56 ^d	33.9 ^a 19-57 ^d	Schizophrenia, psychosis NOS, psychoactive substance use, mania, schizophreniform disorder
GarzaTrevino/ 1989	Median baseline score 60			VAS	15/9	9/12	17/6	Not stated†	Not stated†	Not stated†	Mania, schizophrenia, atypical psychosis, miscellaneous diagnosis
Bieniek/1998	5.2* Not stated		5.5* Not stated	OAS	5/4		8/3	41 ^b 18-50 ^d		35 ^b 18-50 ^d	Mania, psychosis NOS, Sch paranoid, substance induced, brief reactive psychosis, Sch undifferentiated
Barbea/1992	18.5 6.8	18.1 3.5		BPRS (Psychoticism subscale)	8/6	3/11		33.4 ^a 5.8 ^c 18-60 ^d	32.5 ^a 6.2 ^c 18-60 ^d		Schizophrenic patients in psychotic relapse
Dorevitch/1999		49.0 6.6	45.4 6.7	BPRS		5/8	8/7		36.8 ^a 15.1 ^c	34.9 ^a 8.1 ^c	Schizophrenia, schizoaffective disorder, bipolar disorder
Chouinard/ 1993		16.6 5.2	16.8 3.0	IMPS manic symptoms subscale		4/4	6/2		34.6 ^a 10.3 ^c 18-60	35.3 ^a 9.7 ^c 18-60	Bipolar disorder, schizophrenia, schizoaffective disorder, brief reactive psychosis
Salzman/1991		7.1 Not stated	9.0 Not stated	OAS		Not stated	Not stated		37.9 ^a Not stated	30.5 ^a Not stated	Schizophrenia, other (psychotic depression, personality dis, deferred), bipolar disorder, organic mental disorder, schizoaffective disorder
Richards/1998		5.6 0.6	5.3 0.7	Sedation scale score (6 point)		62/40	63/37		33.2 ^a 10.2 ^c >18 ^d	34.6 ^a 10.8 ^c >18 ^d	Methamphetamine toxicity, cocaine toxicity, psychiatric illness, ethanol withdrawal
Foster/1997		61.5 10.7	60.4 11.6	BPRS		14/6	12/5		42.4 ^a 12.0 ^c 18-61	41.4 ^a 10.6 ^c 18-61	Schizophrenia, bipolar disorder, psychotic disorder NOS, schizoaffective disorder
Wyant/1990		Not stated	Not stated	No baseline evaluation		5/0	5/0		43.4 ^a 11.0 ^c 28-59	35.6 ^a 5.2 ^c 28-59	Chronic undifferentiated schizophrenia, chronic paranoid schizophrenia
Richards/1997		5.5 0.6	5.1 0.7	Sedation scale score (6 point)		46/26	52/22		34.6 ^a 10.5 ^c	32.3 ^a 10.2 ^c	Methamphetamine toxicity

*Numeric data are estimated from the graphic presentation. Comb, combination treatment; CI Aps, classic antipsychotic; benz, benzodiazepine. BPRS, brief psychiatric rating scale (11 selected item: hostility, suspiciousness, uncooperativeness, unusual thought content, disorganised conceptualisation, hallucinatory behaviour, grandiosity, anxiety, excitement, tension, mannerisms/posturing); VAS, visual analogue scale for agitation (100 mm); OAS, overt aggression scale; BPRS, brief psychiatric rating scale (psychoticism subscale: suspiciousness, conceptual disorganisation, hallucinatory behaviour, uncooperativeness, unusual thought content, and excitement); BPRS, brief psychiatric rating scale; IMPS, inpatient multidimensional psychiatric scale (manic symptoms subscale: motor overactivity, elevated mood, pressure of speech, logorrhea and insight); Sch, schizophrenia. †Authors have indicated that the distributions of age ranges were comparable across the three treatment groups and were similar to the age range in their pilot study (17-52 years; median age of 31 years).

Table 2 Summary of the studies comparing benzodiazepines, classic antipsychotics, and the combination of both in the treatment of acute agitation

Source/year/design	Study drugs and dosing (mg/injection or dose) and adm route	Improvement rate (%)			Sample size (number included in the analysis)			Definition of improvement	Time for defined improvement	Incidence of EPS side effects (%)			Conclusion	Study environment and duration
		Comb	CI Aps	Benz	Comb	CI Aps	Benz			Comb	CI Aps	Benz		
Battaglia/1997/DBR	Lorazepam 2 mg im/ haloperidol 5 mg im/ combination of them im	91	71	74	32	35	31	Need for 3 or less doses of study medication	3 hours	6	20	3	Combination is significantly more effective	ED/24 hours
GarzaTrevino/1989/random	Lorazepam 4 mg im/ haloperidol 5 mg im/ combination of them im	100	71	83	24	21	23	VAS becoming ≤ 20 mm	60 minutes	Not stated	Not stated	Not stated	Combination is significantly more effective	Not stated/ 210 minutes
Bieniek/1998/DBR	Lorazepam 2 mg im/ haloperidol 5 mg im plus lorazepam 2 mg im	100		55	9		11	Decrease of 4 or more points on OAS	60 minutes	0		0	Combination is significantly more effective	ED/3 hours
Barbea/1992/DBR	Alprazolam 1 mg po plus haloperidol 5 mg po/ haloperidol 5 mg po	93	64		14	14		BPRS psychotism subscale <12, or sedated	4 hours	36	64		Combination is significantly more effective	ED/72 hours
Dorevitch/1999/DBR	Flunitrazepam 1 mg im/ haloperidol 5 mg im		92	80		13	15	Improvement of at least 50% in OAS	90 minutes		0	0	No significant difference in efficacy	Inpatient/2 hours
Chouinard/1993/DBR	Clonazepam 1–2 mg im/ haloperidol 5–10 mg im		75	63		8	8	Improvement of 50% on IMPS manic symptoms subscale	2 hours		13	0	No significant difference in efficacy (CI Aps faster action)	Inpatient and ED/2 hours
Salzman/1991/DB	Lorazepam 2 mg im/ haloperidol 5 mg im		27	59		26	22	% of patients who had greater than mean improvement on OAS	2 hours		50	5	Benz has a significantly superior efficacy	Inpatient/ 24 hours
Richards/1998/random	Lorazepam 2–4 mg iv/ droperidol 2.5–5 mg iv		92	60		102	100	Sedation scale score being <4	30 minutes		1	0	Droperidol (CI Aps) has a significantly superior efficacy	ED/1 hour
Foster/1997/DBR	Lorazepam 2 mg im/po / haloperidol 5 mg im/po		35	36		20	17	% Improvement in BPRS according to baseline	4 hours		0	0	No significant difference in efficacy (Benz po is recommended by authors)	ED/4 hours
Wyant/1990/SBR	Midazolam 5 mg im/ haloperidol 10 mg im/ sodium amytal 250 mg im		34*	75*		5	5	Improvement indicated by CGRS on motor agit mean score, according to maximum possible improvement)	2 hours		Not stated	Not stated	Benz more effective than CI Aps on motor agitation	Inpatient/2 hours
Richards/1997/random	Lorazepam 2–4 mg iv/ droperidol 2.5–5 mg iv		71	55		72	74	% Improvement in sedation scale score according to baseline	60 minutes		1	0	Droperidol (CI Aps) produces more rapid and profound sedation	ED/60 minutes

*Numeric data are estimated from the graphic presentation. DBR, double blind randomised; SBR, single blind randomised; DB, double blind; random, randomised; ED, emergency department. Other abbreviations as in table 1.

Table 3 Demographic and diagnostic features of the studies comparing atypical antipsychotics with classic antipsychotics and/or benzodiazepines and/or placebo in the treatment of acute agitation

Source/ year	Mean baseline agitation score SD			Sample size male/female			Age mean ^a -median ^b SD ^c /range ^d			Final diagnostic impression (in the order of frequency)
	Atyp Aps	Cl Aps	Placebo	Atyp Aps	Cl Aps	Placebo	Atyp Aps	Cl Aps	Placebo	
Currier/ 2001	26.7 5.2	28.5 5.7		23/7	16/14		37.6 ^a 11.3 ^c 18-65 ^d	37.3 ^a 10.7 ^c 18-65 ^d		Psychosis NOS, mania, schizophrenia
Brook/ 2000	45.9 10.5	47.5 9.3		83/7	40/2		34.5 ^a 20-66 ^d	32.8 ^a 19-53 ^d		Schizophrenia, schizoaffective dis, brief psychotic dis, schizophrenif dis, bipolar dis, delusional dis, psychosis NOS
Jones/ 2001*	10.7 3.8	Not stated	Not stated	(stated for the entire sample)	205/106		(stated for the entire sample)	38.2 ^a 11.6 ^c		Schizophrenia, schizophrenif dis, schizoaffective dis
Wright/ 2001*	18.4 3.4	18.2 3.2	18.4 3.5	Not stated	Not stated	Not stated	(stated for the entire sample)	38.2 ^a 11.6 ^c		Schizophrenia, schizophrenif dis, schizoaffective dis
Meehan/ 2001	13.0 3.2	12.7 3.1	12.4 3.0	57/42	29/22	21/30	(stated for the entire sample) 40.2 ^a 12.4 ^c 39.3 ^a 8.5 ^c	40.5 ^a 10.5 ^c	39.0 ^a 9.7 ^c	Bipolar-manic
Yildiz/ 2003†	69.75 18.75	63.60 15.18		1/7	8/2			30.6 ^a 10.0 ^c		Bipolar-manic, depression, psychosis NOS, schizophrenia, borderline personality disorder

*Same study reported in different ways. †The study was conducted at the Harvard Medical School, Massachusetts General Hospital, Acute Psychiatry Service; and the article is in press. Atyp Aps, atypical antipsychotic PANSS†, positive and negative syndrome scale (five directly observable items: excitement, hostility, hallucinatory behaviour, uncooperativeness, and poor impulse control); PANSS‡, positive and negative syndrome scale (excited component: tension, uncooperativeness, hostility, poor impulse control, and excitement); schizophrenif, schizophrenif; schizoaffective dis, disorder. Other abbreviations as in table 1.

main search terms “treatment of acute agitation”, “psychiatric emergency”, “chemical restraint”, “benzodiazepines”, and “conventional antipsychotics”. Augmented by the use of the references listed in the articles identified with the search, this process yielded 128 citations. We selected for further review the reports in which adult psychiatric patients with acute agitation were randomly assigned to treatment with a classic high potency neuroleptic available in the United States or a benzodiazepine or combination of both drugs. For studies to be considered in this review, treatment had to be rendered immediately, and reassessment had to occur in minutes to a maximum of four hours, as the time required for the onset of therapeutic effect is critical in the emergency treatment of agitation. Retrospective studies or the studies comparing the efficacy of two or more neuroleptic agents or two or more benzodiazepines or two or more combination treatments unless either of them was used as a control were excluded.

In a second review through a computer assisted literature search of the National Library of Medicine’s Medline, by using “treatment of acute agitation”, “atypical antipsychotics” as the key words, we identified all efficacy trials of atypical antipsychotics, which included an active and/or inactive comparator for the treatment of acute agitation that has appeared in English since the advent of atypical antipsychotics. Augmented by the use of citations of the review articles on this topic, this process provided 16 citations. We selected for further review the reports in which adult psychiatric patients with acute agitation were assigned to treatment with a novel antipsychotic or a classic high potency neuroleptic or a benzodiazepine or placebo. Retrospective studies or the studies comparing the efficacy of two or more atypical antipsychotic agents or an atypical antipsychotic in two or more different doses are excluded. As the efficacy trials of the novel antipsychotics on the short-term management of agitation are limited; in this review, we included studies in which reassessment scores within the first 72 hours of the pharmacological interventions were reported.

Issues of diagnosis, relative efficacy, dose, route of administration, study duration/environment, sample size, sex, age, assessment scale, and timing for defined improvement are considered. Because of lack of consistency among studies in design, patient selection, rating scales, definition of improvement, and duration of treatment, we could not perform meta-analyses of the published treatment studies in this field. However, we report improvement rates, definition of improvement, and timing of the defined improvement for individual studies, in an attempt to aid an easy interpretation of the relative actions of these drugs in emergency in controlling agitation/aggression. The improvement rates for the individual studies are calculated by the authors based on the data provided in the corresponding studies unless they were originally given as percentages.

RESULTS

Review 1 Classic antipsychotics versus benzodiazepines and/or combination of both

In our first review, 11 trials meeting our inclusion criteria were identified.^{9 18-27} Of these 11 trials, eight used a blind design. The total number of subjects was 701 (tables 1 and 2).

There were four studies rendering the combination treatment as a study arm.¹⁸⁻²¹ All of the four trials reported the combination treatment to be significantly more effective than the comparison group. Two of them were three armed studies comparing lorazepam plus haloperidol to each drug alone. They established that combination treatment was superior to either drug alone.^{18 19} Three studies evaluating the side effects reported fewer incidences of extrapyramidal system (EPS) side effects in the combination group than the group taking classic antipsychotic alone (table 2).

Table 4 Summary of the studies comparing comparing atypical antipsychotics with classic antipsychotics and/or benzodiazepines and/or placebo in the treatment of acute agitation

Source/ year/design	Study drugs and dosing (mg/injection or dose) and adm route	Improvement rate (%)				Sample size (n included in the analysis)					Definition of improvement	Time for defined improvement	Incidence of EPS side effects (%)				Conclusion	Study environme nt and duration
		Atyp Aps	CI Aps	Placebo	Benz	Atyp Aps	CI Aps	Placebo	Benz	Atyp Aps			CI Aps	Placebo	Benz			
Currier/ 2001/rater blinded	Risperidone 2 mg po plus lorazepam 2 mg po/ haloperidol 5 mg im plus lorazepam 2 mg im	62	71			30	30				% Improvement in PANSS according to baseline	60 minutes	0	3			No significant difference between the two treatment groups	ED/24 hours
Brook/ 2000/ random	Ziprasidone 10 mg im/ haloperidol 2.5–10 mg im	13	7			83	40				% Improvement in BPRS according to baseline	72 hours	0	21.4			Ziprasidone is significantly more effective and better tolerated	Inpatient/ 72 hours
Jones/ 2001* / DBR	Olanzapine 10 mg im/ haloperidol 7.5 mg im/ placebo im	27	Not stated	Not stated		122	116	47			% Improvement in BPRS positive subscale according to baseline	2 hours	Not stated	Not stated	Not stated	Olanzapine and haloperidol are superior to placebo but not significantly differ from each other	Inpatient/ 24 hours	
Wright/ 2001* / DBR	Olanzapine 10 mg im/ haloperidol 7.5 mg im/ placebo im	73	69	33		131	126	54			Improvement of at least 40% in excited component of PANSS	2 hours	0.8	5.6	Not stated	Olanzapine is not inferior to haloperidol in efficacy; has a significantly more rapid onset of action	Inpatient/ 24 hours	
Meehan/ 2001/DBR.	Olanzapine 10 mg im/ lorazepam 2 mg im / placebo im	74		38	54	98		50	51		% Improvement in excited component of PANSS according to baseline	2 hours	No significant difference in EPS side effects			Olanzapine is superior to placebo and lorazepam in reducing agitation	Not stated/ 24 hours	
Yildiz/ 2003†/ observ	Risperidone 1–2 mg po ± lorazepam 1 mg po/ haloperidol 2–5 mg im or po ± lorazepam 1–2 mg im or po	57	41			8	10				% Improvement in BPRS according to baseline	2 hours	0	0		Risperidone is not inferior to haloperidol in efficacy	ED/2 hours	

*Same study reported in different ways. †The study was conducted at the Harvard Medical School, Massachusetts General Hospital, Acute Psychiatry Service; and the article is in press. Observ, observational. Other abbreviations as in table 1.

Among the seven studies comparing a benzodiazepine with a classic antipsychotic, improvement rates with the classic antipsychotic group were higher than the benzodiazepine group in four studies.^{9, 22-27} However, two studies reported an insignificant difference in efficacy, while in the other two, droperidol was the classic antipsychotic agent used,^{25, 27} which was found to have a significantly superior efficacy than the benzodiazepine comparator. In three studies, improvement rates in the benzodiazepine group were higher than the classic antipsychotic group. Two of these studies found a significant difference in the anti-agitation effect of the benzodiazepine over the classic antipsychotic comparator. In one study, the difference in the improvement rates was found insignificant, however, the authors have recommended the use of benzodiazepine by mouth as a first line anti-agitation compound. Six studies evaluating the side effects reported fewer incidences of EPS side effects in the benzodiazepine group than the group taking classic antipsychotic (table 2).

These studies taken together suggest that combining haloperidol, 5 mg, and lorazepam, 2 mg, orally or intramuscularly (in the same syringe) as required is an effective approach to the rapid tranquilisation of the agitated patient in emergency settings.

Review 2 Atypical versus classic antipsychotics and/or benzodiazepines and/or placebo

In our review of atypical antipsychotic agents as acute anti-agitation compounds, five comparison trials (six reports) were identified using a classic antipsychotic or a benzodiazepine or placebo as a comparator to an atypical antipsychotic agent.²⁸⁻³³ Three of these studies used a blind design.^{28, 31, 32} The total number of subjects was 711 (five trials), of which 15% (104) was assigned to the placebo arm (tables 3 and table 4).

Improvement rates with atypical antipsychotic agents were higher than the corresponding active comparator (in two studies, haloperidol; in one study, lorazepam) in four of the six reports,^{29, 31-33} this difference was found significant in three of them.^{29, 31, 32} The other three reports indicated that the atypical antipsychotic agent was found to be as effective as its active comparator and/or significantly superior to placebo. All the five trials have evaluated the side effects, with three reporting fewer incidences of EPS side effects in the atypical antipsychotic group than the classic antipsychotic group (table 4). In two studies route of administration was orally (table 4).^{28, 33} In the first report with orally atypical antipsychotic, Currier and Simpson showed that a substantial number of patients who are in an emergency setting would otherwise have received intramuscular drugs were indeed willing to accept an oral alternative.²⁸ Furthermore, in this population, oral atypical antipsychotic in combination with an oral benzodiazepine seem to be equally calming and at least as tolerable as injectable alternatives.²⁸ Our own experience in the pilot study is totally in accordance with this.³³

DISCUSSION

This review found that atypical antipsychotics in moderate doses are effective treatment alternatives for agitation in emergency situations. Given the postulated mechanisms underlying agitation in different psychiatric conditions, atypical antipsychotic agents by virtue of their activities on various dopaminergic, serotonergic, noradrenergic, and histaminergic receptors are likely to provide a distinctive anti-agitation effect.¹

As reflected in the clinical data, among the available atypical antipsychotics, supportive information is available for the use of risperidone, ziprasidone, and olanzapine, which seem to be proper alternatives in the treatment of acute agitation (table 4). In addition to their broader efficacy, and better safety profiles, using these compounds for the treatment of acute

agitation offers an opportunity for a pharmacological continuum by transferring the patients to oral maintenance treatment as indicated once their acute symptoms have been ameliorated.³⁴ Moreover, protection against EPS with these compounds is important as EPS experienced in the acute emergency setting may have an adverse effect on subsequent treatment compliance and cooperation by the patient in the long term. This benefit of atypical antipsychotics is particularly significant, as non-compliance is thought to be responsible for about 40% of hospital readmissions two years after discharge.¹⁷

In addition, while the investigations are taking place to rule out organicity behind the agitation, it will be safer to use atypical antipsychotics as they have less risk to effect the vital signs including blood pressure compromise the vital in that sense. None the less, the emergency physician should give the highest possible attempt to establish the underlying diagnosis behind the agitation before making any treatment decision. Excluding the cases with organicity, treatment alternatives should be explained to the agitated patient. Besides, the patient should be offered to take an active role in the treatment decision whenever possible.

Intramuscular compared with oral route of administration in emergency treatment of agitation

When an agitated patient walks in an emergency department the primary focus is often to stabilise the positive symptoms and parapositive symptoms in a rapid time course, which may lead to overuse of physical/chemical restraints.¹⁵ As a result of documentation of the traumatic aspects of restraints, the US Health Care Finance Administration's (HCFA) new interim final rules concerning use of physical and chemical restraints.³⁶ According to this, "A drug used as a restraint is not a standard treatment for the patient's medical and psychiatric condition" and patient participation in the planning and conduct of treatment and the right to refuse unwanted treatment are the central premises of the regulations.³⁶ In that sense, the indications for the use of involuntary treatment with an intramuscular route need to be re-evaluated in the light of some of the commonly overlooked potential impacts on the patients' acute and subacute course.

Compliance of the patients with medication treatment may be influenced by their experiences in emergency setting.⁴ An injectable medication use is likely to be experienced as an assault invoking images of punishment and incarceration for the patient rather than those of therapy and relief.³⁷ As a result, this can influence the establishment of therapeutic alliance between the patient and caregivers and affect compliance and cooperation with subsequent treatment.³⁷

The clinicians need to understand the dynamics of agitation/aggression. Aggressive behaviour is frequently the result of an acute narcissistic injury.³ Besides, the aggressive patient's behaviour frequently leads to circumstances that cause additional shame and embarrassment, such as police action, restraint and seclusion, and psychiatric evaluation.³ The clinician must avoid responding to the patient's aggression in a punitive manner, instead take action with a respectful, non-judgmental, and reassuring attitude such as offering the patient an active choice in their treatment suggesting an internal rather than an external locus of control.³

The advantages and disadvantages of choosing an intramuscular route have to be considered seriously for a rapid behavioural control in agitation. Interestingly, there is evidence indicating that oral drugs can be as effective as the intramuscular ones, and the onset of action of intramuscular drugs is not significantly more rapid to warrant its use as a first intervention.³⁸⁻⁴² In a recent study, Foster *et al* found no significant interaction between administration route and improvement rates.⁹ Indeed, the most important "advantage" of an intramuscular route is in involuntary treatment.

However, despite the belief that patients may be too agitated and uncooperative to take oral drugs, it has been shown that that most patients will indeed cooperate with an oral dosing regimen.^{28 38-42}

In a recent survey, it was found that most medical directors of psychiatric emergency programmes would prefer to administer an oral atypical agent if such an agent were found to be effective, safe, reliable, and practical to use.⁴ Consequently, intramuscular treatment should be reserved for the agitated patients for whom parenteral treatment is the only feasible alternative.

CONCLUSIONS

This review provided support from the literature for the effective use of antipsychotic medications and benzodiazepines in controlling agitation and aggression in emergency settings. The conclusions of the review were: (1) A combined use of a classic antipsychotic and a benzodiazepine may produce an anti-agitation effect superior to either drug alone in a safer manner. (2) Some of the atypical antipsychotic agents are at least as effective as the classic high potency alternatives and/or benzodiazepines providing a better safety profile. (3) Agitation and aggressive behaviour seem to be linked to abnormalities in dopaminergic, serotonergic, noradrenergic, and sometimes glutamatergic-GABAergic systems. Accordingly, atypical antipsychotic agents by virtue of their activities on various dopaminergic, serotonergic, noradrenergic, and histaminergic receptors may possess a distinctive anti-agitation effect. In situations where a reduced GABAergic transmission is suspected combining an atypical antipsychotic with a benzodiazepine would be beneficial. (4) As drugs are often prescribed before assessment in emergency settings, associated physical and psychiatric illnesses may be overlooked.^{36 37} Thus, safety of the anti-agitation compound is at least as important as its efficacy; and atypical antipsychotics have a better safety profile than the classic ones. While the investigations are taking place to rule out organicity behind the agitation, it will be safer to use atypical antipsychotics as they have less risk for affecting the vital signs including blood pressure. (5) This review indicates that a comparatively benign psychopharmacological intervention may be adequate to calm agitated psychiatric patients and an oral route of administration should always be offered first. This would build up an alliance with the patient and suggest an internal rather than external locus of control. Present data suggest that oral treatment with an atypical antipsychotic (with or without a benzodiazepine) may be as effective as the intramuscular injection route with a classic antipsychotic drug. Therefore, an overreliance on an intramuscular route of administration should be avoided and intramuscular treatment should be reserved for patients who cannot cooperate with the treatment/physician or favour the intramuscular treatment. In these cases, where an injection is required, the least offensive drug should be used. Timing for reassessment of agitation should then be adjusted according to the route of administration; and should occur in about 30 minutes after intramuscular administration and 30 to 60 minutes after oral administration of drugs.³⁶ Non-responders may receive additional medications in oral or intramuscular formulations as needed. (6) Based on the available data to date, among the present novel antipsychotic agents, risperidone, ziprasidone, and olanzapine seem to be more fitting as acute antiagitation compounds.

As more data become available on the use of atypical compared with classic antipsychotics and benzodiazepines in emergency situations, further refinement of the treatment of agitation/aggression and the development of specific algorithms will be viable.

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Contributors

Aysegül Yildiz initiated and formulated the primary study hypothesis, designed the protocol, collected and documented the data and wrote the paper. Gary Sachs discussed core ideas, participated in the design, and execution of the study particularly data documentation and quality control. Atilla Turgay discussed core ideas and interpretation of the findings, and edited the paper. Aysegül Yildiz and Atilla Turgay are the authors who will act as "guarantors".

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