

Peripartum Agitation

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Peripartum Agitation

Peripartum Agitation Basics

Definition: Combative and aggressive behavior, physical restlessness, or extreme irritability (1). Agitation in pregnancy is an **obstetric emergency** due to risk of harm to mother and/or baby/fetus.

Risks of untreated peripartum agitation: Preterm delivery, placental abnormalities, low birth weight, postnatal death, spontaneous abortion (3).

Determine the cause!

- Medical sources of agitation (2,3)
 - o Delirium due to medical condition, amniotic or venous thromboembolism, pre-eclampsia/eclampsia, hyperthyroidism, trauma, infection, etc.
 - o Substance Intoxication or Withdrawal
 - o Pain
 - o Traumatic Brain Injury (TBI)
- Psychiatric sources of agitation (2-4)
 - o New onset vs exacerbation/decompensation of existing condition.
 - o Abrupt discontinuation of psychotropic medications due to concern over fetal risk (1).
 - o Post-partum psychosis
 - o "Personality" characteristics, maladaptive coping patterns

Step 1: Verbal De-escalation & Behavioral Redirection

Verbal Strategies (2,3)

- Speak slowly in calm, low voice. Be concise.
- o Be present and genuine.
- o Convey empathy by listening, validating, and providing accurate reflections. *"It sounds like you are feeling overwhelmed for a lot of good reasons."*
- o Normalize emotions. *"I know you feel like ___ and that must be tough. Others in this predicament have also felt this way. In my experience, I have found that ____."*
- Identify wants/needs. *"What helps you at times like this?"*
- 'Agree' or 'Agree to Disagree.' Do not be provocative

Ensure safety of yourself, staff & scene (1)

- Ensure patient and the room are free of safety hazards/weapons.
- Remain at a safe distance from patient with clear exit from room.
- Alert appropriate security personnel and/or have mechanism for alerting additional staff/security.

Behavioral Strategies (2,3)

- Respect personal space
- Limit the number of people in the room. Use patient's preferred caregivers when possible.
- Keep the environment as "low stim" as possible
- Offer comfort items (warm blanket, food, etc.)
- Offer choices/options
- Pause if medically possible. *"Do you need to take a short break?"*
- Offer a PO medication *"I think you would benefit from medication" or "I think you need a medication."*

Step 2: Pharmacologic Intervention

Goal: Maintain safety of patient and providers during assessment and treatment

Choosing a medication:

- Never feel like you have to order a medication immediately. If unsure, go lay eyes on the patient.
- Choose medication based on most likely underlying cause of agitation when possible (ex. lorazepam for alcohol withdrawal, antipsychotic for psychosis, etc; 2,3)
- Limit number of medications. Give patients known medications first to limit exposures to fetus.
- Match IM/PO/IV medications.
- Consider onset of action
 - o IV works the fastest: approximately 5-20 minutes.
 - o PO generally takes at least 30 mins-1 hour.
- Choose a medication appropriate for the severity of agitation (3)
 - o **Mild: PO meds**
 - Diphenhydramine 25 – 50 mg PO, IM (can worsen delirium)
 - o **Moderate: Consider IV/IM**
 - Haloperidol 0.5 mg – 2 mg PO, IV, IM
 - Olanzapine 2.5 mg – 5 mg Rapidly dissolving, PO, IM (do not co-administer IM olanzapine and benzodiazepine; following IM olanzapine, wait at least one hour and monitor for respiratory depression prior to use of benzo)
 - Lorazepam 0.5 – 2 mg PO, IV, IM
 - o **Severe: IV/IM**
 - Haloperidol +/- lorazepam +/- diphenhydramine

Administering medications:

- Offer PO first to honor autonomy.
- Use IM/IV only if refusal of PO, Danger to Self (DTS) and/or Danger to Others (DTOs).
- If does not have decisional capacity (ex. floridly delusional), okay to start with IV option.
- Start with PRN option. Recommend scheduling medications if persistent, regularly occurring agitation.
- Taper/Discontinue once agitation has resolved for a few days.
- Put in a not to exceed (NTE) in order.

Safety of Medications for Agitation in Pregnancy*

- Anti-psychotics
 - o Most pregnancy data is on haloperidol, olanzapine, and quetiapine.
 - Haldol (1st gen) is less likely to have sedative or hypotensive effects than second gen (3) but more likely to have EPS.
 - o One-time doses are generally low risk (1).
 - o If frequent administration of anti-psychotics in 3rd trimester, newborns should be monitored for risk of neonatal EPS, sedation, breathing and feeding difficulties, increased/decreased muscle tone, agitation, tremor. These complications may resolve on their own or require additional hospitalization (7).
- Benzodiazepines
 - o PO lorazepam has been safely administered during delivery of full-term infants, even at high doses. Use caution with IV lorazepam and in preemies (10).
 - o If frequent administration during third trimester, monitor newborns for floppy baby or neonatal withdrawal syndrome (sedation, hypotonia, feeding difficulties).
- Contra-indicated: valproic acid (not generally used for acute agitation)
- Dosing: Medications metabolized by CYP P450 enzymes more rapidly metabolized during pregnancy and may require higher doses, including lorazepam, clonazepam, quetiapine.

**For more details about specific medications and effects during pregnancy, see table below.*

Step 3: Restraints as a last resort during pregnancy

Use as a **last resort** only if:

1. Imminent risk to mother, fetus/newborn, and/or staff
2. Failure of prior interventions/least restrictive options

DO: Use least restrictive options possible (fewer restraints the better). Continue frequent monitoring of patient/vital signs/fetal heart tones while in restraints. Ensure adequate comfort, hydration, nutrition, and medical stability throughout process. Limit/end restraints as much as possible.

DO NOT USE: abdominal restraints, restraints that increase risk of falling forward (wrist restraints behind the back), four-point restraints, restraints during labor & delivery, use out of convenience or punishment (5).

>20 weeks: Place pregnant patient partway to the left with support under the right hip – right hip should be 10-12 cm off the bed with supporting pillows/blankets. **Do not restrain in supine position or on right side** due to risk of inferior vena cava compression syndrome (hypotension, tachycardia, fetal distress due to compression vena cava, blocking flow of venous blood to the heart; 5).

Be mindful of implicit bias and thoughtful about escalation of interventions

Ethical Considerations & Decisional Capacity

Weigh **patient autonomy vs beneficence** to the birthing parent and baby.

Evaluate decisional capacity:

- Decisional capacity is evaluated on a moment-to-moment basis about each medical decision
- Patients have decisional capacity when they can:
 - o Voice a clear and consistent **choice**
 - o **Understand** the relevant medical information
 - o **Appreciate** the situation and its consequences
 - o Explain their **rationale**
- The stringency of this assessment depends on the risk-to-benefit ratio. A patient can **assent** to a life-saving procedure even if they do not have decisional capacity and therefore cannot complete full **informed consent**. This is an attempt to preserve patient autonomy.

If a patient **lacking decisional capacity** refuses treatment: (8,9)

- If possible, consult the hospital's clinical ethics team and legal counsel
- Determine whether the intervention is **medically necessary** (e.g. cesarean section for complete placenta previa) and whether it is **urgent/emergent**
- **Assisted decision-making:** If there is time, first attempt to restore capacity using verbal interventions, respectful persuasion, and pharmacologic interventions as necessary.
- **Surrogate decision-making:** If patient is still refusing, a legally designed surrogate or advance directives from the patient meet the **substituted judgment** standard.
- **Coerced clinical management:** If patient still cannot assent to medically necessary treatment, then proceeding with treatment can be ethically justified if nonintervention would cause more harm to the mother and/or baby. Continue to explain what is happening to the patient and attempt to minimize their stress/anxiety.

Peripartum Agitation Medications

Medication	Indications	Birthing parent Side Effects	Effects on Fetus	Starting Dose & Ranges	Onset of Action	Notes
Haloperidol (1 st line if etiology of agitation unknown)	<ul style="list-style-type: none"> • Mod/Severe Agitation • Delirium/ Organic etiology • Primary Psych (ex. psychosis) 	<ul style="list-style-type: none"> • EPS (higher risk) • Dystonia • Sedation • NMS • Anti-cholinergic Effects • QTc prolongation (worse with IV) 	Risk of neonatal EPS for ongoing use; no data of increased risk from one time use.	<ul style="list-style-type: none"> • PO: 0.5-1 mg TID PRN • IV: 0.5 - 2 mg TID PRN • IM: 5 mg once time • Can increase to 4-20 mg/day • NTE: 20 mg/day 	PO: 45 – 60 mins IV > IM: 15 – 30 mins	<ul style="list-style-type: none"> • Get EKG baseline to evaluate QTc. Continue to monitor with increased doses. • IV preferred over IM if IV available (IM higher risk of EPS) • IM: recommend giving with diphenhydramine 25 – 50 mg to prevent EPS
Olanzapine (alternative choice)	<ul style="list-style-type: none"> • Mod/Severe Agitation • Primary Psych (ex. mood stabilization, psychosis) 	<ul style="list-style-type: none"> • Sedation • Orthostatic hypotension • EPS • Metabolic syndrome 	FDA warning (updated 2011) for EPS, sedation, breathing/ feeding difficulties, agitation, tremor, change in muscle tone; may resolve spontaneously or require additional hospital care.	<ul style="list-style-type: none"> • PO: 2.5 – 5 mg PO or IM BID PRN • Can increase to 10-20 mg/day • NTE: 20 – 30 mg/day 	PO: 30 mins – 1 hour IM: 15 – 30 minutes	<ul style="list-style-type: none"> • Get EKG baseline to evaluate QTc. Continue to monitor with increased doses. • Do not administer IM medication with benzodiazepine (risk of respiratory distress) • Highest placental transfer (72.1%)
Quetiapine (alternative choice)	<ul style="list-style-type: none"> • Primary psych (mood stabilization) • Delirium • Anxiety 	<ul style="list-style-type: none"> • Sedation • Weight gain • Metabolic syndrome • Possible risk of increased gestational diabetes 		<ul style="list-style-type: none"> • 25 – 100 mg PO • NTE: 300 mg daily for agitation 		<ul style="list-style-type: none"> • Lowest possible placental transfer (3.7%)
Lorazepam (preferred benzo in pregnancy)	<ul style="list-style-type: none"> • Alcohol or Benzo withdrawal • Stimulant intoxication • AMS 2/2 NMS, serotonin syndrome, catatonia • Personality 	<ul style="list-style-type: none"> • Sedation • Respiratory distress • Memory Impairment • Risk of falls/ Incoordination • Tolerance • Dependence • Withdrawal 	Exposure associated with “floppy baby” syndrome and neonatal withdrawal (requiring ICU admission); more likely from long term use	<ul style="list-style-type: none"> • 0.5 – 2 mg PO, IV, IM • up to 2-3 times daily • Increase as needed to 2-6 mg daily divided in doses • NTE: 10 mg/day in divided doses 	PO: 15 – 30 mins IM, IV: rapid	<ul style="list-style-type: none"> • Black box warning: avoid use with opioids; abuse/misuse potential
Diphenhydramine	<ul style="list-style-type: none"> • Mild agitation • Anxiety 	<ul style="list-style-type: none"> • Sedation • Anti-cholinergic effects • GI distress • Impaired coordination 	One case report of neonatal withdrawal symptoms (irritability, sedation, tremulous, diarrhea).	<ul style="list-style-type: none"> • 25 – 50 mg PO, IV, or IM • Q1-4 hours • NTE: 300 mg/day 	PO: 15 – 20 mins IM, IV: rapid	<ul style="list-style-type: none"> • Dose dependent anti-cholinergic effect can make delirium worse

Peripartum Agitation References and Resources

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