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 associated with untreated peripartum agitation: Preterm delivery, placental abnormalities, low birth weight, postnatal death, spontaneous abortion (3). Agitation secondary to untreated alcohol withdrawal increases risk for preterm birth and low birth weight (1).

Determine the cause!

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

Step 1: Verbal De-escalation & Behavioral Redirection

Verbal Strategies (2,3)

- Speak slowly in calm, low voice. Be concise.
- Be present and genuine.
- Convey empathy by listening, validating, and providing accurate reflections. *"It sounds like you are feeling overwhelmed for a lot of good reasons."*
- 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
    - IV works the fastest: approximately 5-20 minutes.
    - PO generally takes at least 30 mins-1 hour.
- Choose a medication appropriate for the severity of agitation (3)
    - Mild: **PO meds**
        - Diphenhydramine 25 – 50 mg PO, IM (can worsen delirium)
    - 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
    - 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
    - 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.
    - One-time doses are generally low risk (1).
    - 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
    - PO lorazepam has been safety administered during delivery of full-term infants, even at high doses. Use caution with IV lorazepam and in premies (10).
    - 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:
    - Voice a clear and consistent **choice**
    - **Understand** the relevant medical information
    - **Appreciate** the situation and its consequences
    - 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 (1st line if etiology of agitation unknown)	• Mod/Severe Agitation • Delirium/ Organic etiology • Primary Psych (ex. psychosis)	• 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. FDA warning (updated 2011) for EPS, sedation, breathing/ feeding difficulties, agitation, tremor, change in muscle tone; may resolve spontaneously or require additional hospital care.	• 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	• 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)	• Mod/Severe Agitation • Primary Psych • (ex. mood stabilization, psychosis)	• Sedation • Orthostatic hypotension • EPS • Metabolic syndrome		• 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	• 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)	• Primary psych (mood stabilization) • Delirium • Anxiety	• Sedation • Weight gain • Metabolic syndrome • Possible risk of increased gestational diabetes		• 25 – 100 mg PO • NTE: 300 mg daily for agitation		• Lowest possible placental transfer (3.7%)
Lorazepam (preferred benzo in pregnancy)	• Alcohol or Benzo withdrawal • Stimulant intoxication • AMS 2/2 NMS, serotonin syndrome, catatonia • Personality	• 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	• 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	• Black box warning: avoid use with opioids; abuse/misuse potential
Diphen-hydramine	• Mild agitation • Anxiety	• Sedation • Anti-cholinergic effects • GI distress • Impaired coordination	One case report of neonatal withdrawal symptoms (irritability, sedation, tremulous, diarrhea).	• 25 – 50 mg PO, IV, or IM • Q1-4 hours • NTE: 300 mg/day	PO: 15 – 20 mins IM, IV: rapid	• Dose dependent anti-cholinergic effect can make delirium worse

Peripartum Agitation References

1. Lisette, Rodriguez-Cabezas and Clark Crystal. Psychiatric Emergencies in Pregnancy and Post-Partum. Psychiatric emergencies in pregnancy and postpartum.pdf. *Clin Obstetrics gynecology Sept 2018.*
2. Wilson, Michael P, Kimberly Nordstrom, et al. Psychiatric Emergencies in Pregnant Women. http://dx.doi.org/10.1016/j.emc.2015.07.010. *Emergency Med Clin Elsevier Inc. 2015*
3. Niforatos, Joshua, Wanta, Jonathon, et al. How should I treat acute agitation in Pregnancy?. https://consultqd.clevelandclinic.org/how-should-i-treat-acute-agitation-in-pregnancy/
4. Aftab A, Shah AA., et al Behavioral emergencies: special considerations in the pregnant patient. *Psychiatry Clin North Am 2017; 40(3):435–448.*
5. Best Practices int he Use of Restraints with Pregnant Women and Girls Under Correctional Custody. http://www.nasmhpd.org/sites/default/files/Best_Practices_Use_of_Restraints_Pregnant%282%29.pdf. *Bureau of Justice Assistance. U.S. Department of Justice. 2014.*
6. Garriga, Marina, Pachiarotti, Isabella, et al. Assessment and management of agitation in psychiatry: Expert consensus. https://pubmed-ncbi-nlm-nih-gov.offcampus.lib.washington.edu/26912127/. World J Biology Psychiatry. 2016.
7. Yan, Jun. FDA extends Black-Box Warning to All Anti-psychotics. https://psychnews.psychiatryonline.org/doi/10.1176/pn.43.14.0001. Psychiatry News, American Psychiatric Association. Jul 18, 2008.
8. McCullough LB, Chervenak FA, Coverdale JH. Managing Care of an Intrapartum Patient with Agitation and Psychosis: Ethical and Legal Implications. AMA J Ethics. 2016 Mar 1;18(3):209-14. doi: 10.1001/journalofethics.2016.18.3.ecas2-1603. PMID: 27002991.
9. Babbitt KE, Bailey KJ, Coverdale JH, Chervenak FA, McCullough LB. Professionally responsible intrapartum management of patients with major mental disorders. Am J Obstet Gynecol. 2014 Jan;210(1):27-31. doi: 10.1016/j.ajog.2013.06.024. Epub 2013 Jun 18. PMID: 23791565.
10. Whitelaw AG, Cummings AJ, McFadyen IR. Effect of maternal lorazepam on the neonate. Br Med J (Clin Res Ed). 1981 Apr 4;282(6270):1106-8. doi: 10.1136/bmj.282.6270.1106. PMID: 6113019; PMCID: PMC1505046.