STATUS EPILEPTICUS

Ask for senior advice

- ABC + oxygen by NRRM
- Check blood glucose
- IV diazepam up to 10 mg slowly iv
- Phenytoin 15mg/kg by iv infusion (unless patient is on this already) (max. 1g)
- Consider 'Pabrinex' slow iv if history/suspicion of chronic alcohol excess

- Seek anaesthetic help
- Consider paraldehyde
- Consider phenobarbitone

Seek an underlying cause especially:

- Focal neurology – CT
- Injury – CT
- Fever or sepsis – consider acyclovir + cefotaxime
- Poisoning – try to get more history

One of the commonest causes of non-responding status is pseudoseizures – this diagnosis should only be considered by a very experienced doctor – seek help

FITS, FAINTS AND FUNNY TURNS (SEE STATUS EPILEPTICUS, STROKE, TIA AND TLOC)

Many will require outpatient investigation but few require admission, although patients who live alone should not be discharged alone; family help or a care package should be sought. Although alarming for patients, carers and doctors, most have a benign prognosis.

"Funny turn" describes an ill-defined episode of impaired consciousness from which the patient has more or less recovered by the time they reach Emergency Department. This is an extremely common presentation to Emergency Department so you must develop a good system for rapidly evaluating these patients. The cause for the funny turn is usually cardiovascular or neurological. A meticulous history including an eyewitness account is the single most important aid to diagnosis. What was the patient

doing just before the attack? Ascertain whether or not consciousness was lost. If it was, rapid recovery suggests CVS cause, while more gradual recovery suggests NS. Was there injury, tongue biting or incontinence? Is there a history or family history of heart disease or epilepsy?

(Contrary to popular belief, TIA is an uncommon cause for transient loss of consciousness.)

A full history is imperative to include pre-morbid history, prodromal symptoms, length of time unconscious, degree of amnesia and confusion on recovery.

- A neurological cause, for example, epilepsy, SAH, can often be identified by the history, examination and the appropriate referral made.
- 50% of all cases have a cardiac cause and again, these can be determined by history, examination and ECG. Investigate and treat accordingly.

The remaining cases can be classified under five categories

1. Simple Faint
Definite provocational factors with associated prodromal symptoms and which are unlikely to occur whilst sitting or lying. Benign in nature.
These patients can often be discharged home from the ED without follow-up.

If recurrent, will need to check the 3 “Ps” apply on each occasion
Provocation Prodrome Postural
(If not see Number 3 below).

2. Loss of consciousness/ loss of or altered awareness likely to be unexplained syncope and low risk of re-occurrence
These have no relevant abnormality on CVS and neurological examination and normal ECG.
Consider the TLOC guidelines

3. Loss of consciousness/ loss of or altered awareness likely to be unexplained syncope and high risk of re-occurrence
Factors indicating high risk:
(a) abnormal ECG
(b) clinical evidence of structural heart disease
(c) syncope causing injury, occurring at the wheel or whilst sitting or lying
(d) more than one episode in previous six months.
These patients usually need admitted under cardiology team, especially if first occurrence. Further investigations such as ambulatory ECG (48hrs), echocardiography and exercise testing may be indicated after specialist opinion has been sought.

4. Presumed loss of consciousness/loss of or altered awareness with seizure markers

The category is for those where there is a strong clinical suspicion of epilepsy but no definite evidence.

The seizure markers act as indicators and are not absolutes

a) unconsciousness for more than 5 mins.
b) amnesia greater than 5 mins
c) injury
d) tongue biting
e) incontinence
f) remain conscious but with confused behaviour
g) headache post attack

For patients presenting with first (possible) seizure consider Observation Ward pathway, if multiple episodes admit under medical team. Discharged patients should be referred to neurology OPD if not already under their care.

5. Loss of consciousness/loss of or altered awareness with no clinical pointers

This category will have had appropriate neurology and cardiac opinion and investigations but with no abnormality detected. These patients should be admitted under appropriate team as clinically indicated.

All patients should have:

- Their medication list scrutinised (check ECR)
- Thorough CVS examination including erect & supine BP (wait 1 min and 3 mins to check erect BP) and auscultation of the neck.
- Thorough NS examination including fundoscopy
- An ECG – any arrhythmia or a QT_c > 460mseconds is an indication for cardiac referral.

The term "**Faint**" should be reserved for a vasovagal episode, usually in younger patients. It is usually preceded by nausea, vomiting, and sweating and often relates to some kind of situational stress. Some patients who faint will have a very brief convulsion especially if not allowed to lie flat.

A "**Drop Attack**" is a sudden falling to ground without loss of consciousness. Usually caused by a balance problem or postural hypotension.

A **seizure** may be 'generalised' or 'partial' (+/- complex). A change to fit pattern usually merits admission to the medical ward. Beware of the post-ictal patient who has not fully recovered - always observe for a while and mobilise prior to discharge. Don't forget to exclude injury - skull fracture and dislocated shoulder are the commonest.