



The ED Treatment of Seizure and SE Patients: What the 2004 ACEP Seizure Clinical Policy Doesn't Tell You

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Case Presentation

A 66 year old female acutely developed aphasia and left sided weakness while watching TV at home. She then began to have a tonic-clonic seizure. The paramedics give diazepam, and the seizure appears to resolve. Upon arrival in the ED, the patient remains unresponsive, and then again begins to have a generalized seizure. What is the best approach in managing this patient?

The 2004 ACEP clinical policy on the Emergency Department treatment of seizure and status epilepticus patients asks three questions:

How should a phenytoin be loaded?

What should be given to a seizing patient after a benzodiazepine and a phenytoin?

When is an EEG indicated in the ED?

Although there are evidence-based answers provided in the guidelines, these answers are somewhat limited by the fact that there is very little scientifically proven information that will support definitive recommendations that can be interpreted as being “standards”. As such, clinical judgment by the EM physician is still necessary. Hence, the need to know what the policy doesn't tell you...

Key Clinical Questions Related to the ACEP Seizure Policy

When treating seizure and status epilepticus patients, what is the pathology that we are actually treating?

How can the emergency physician simply classify Sz/SE patients?

What is an acceptable SE protocol to be used in the Emergency Department and other parts of the hospital?

What is a reasonable time frame for the treatment of seizing ED patients?

What therapies can be used for seizing ED patients?

What therapies should be used for seizing ED patients?

How can these therapies be provided in an efficient manner?

Based on what evidence and consensus should these treatment decisions be made? Why? In which patients?

The purpose of this presentation is to augment the ACEP clinical policy by provided more detailed information regarding how seizure therapies can be optimally utilized based on the specifics of the individual seizure patient being treated. In doing so, it is hoped that emergency physicians will be able to learn more, become more proficient in treating seizure and SE patients, improve patient outcome, and enhance their clinical practice.