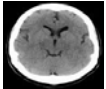

**Optimizing Seizure and SE
Patient Management:
Seizure Therapies
Workshop and Clinical
Policy Review**



Edward P. Sloan, MD, MPH



**Clinical Decisions in
Emergency Medicine**

**Ponte Vedra, FL
June 22-23, 2007**

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Patient EMS Data

- 50?? yo male John Doe
- Generalized tonic-clonic seizure
- Chicago Fire Department
- Diazepam 5 mg IM, 15 mg IV
- Seizure continuous for 15 minutes +
- EMS to ED

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Patient Clinical History

- Unknown meds
- Unknown medical history
- Hx Needs surgery next month ??
- EtOH ??
- Does not appear to be homeless
- Accucheck 119

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ED Presentation

- Facial and shoulder twitching R
- Pt with gurgling BS
- Nasopharyngeal airway
- No evidence of trauma or toxicity
- IV access in neck
- Seizure persists x minutes

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ED Patient Outcome

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ED Patient Management

- Lorazepam 2 mg IVP x 5 over 10 minutes
- Persistent facial and R shoulder activity
- AMS: generalized seizure continues
- Fosphenytoin 1 gram PE over 10 min x2
- Seizure ended, pt remained obtunded
- Intubation immediately followed
- Lidocaine, sux, rocuronium

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ED Diagnostic Evaluation

- Non-contrast CT: Prior strokes, atrophy
- Metabolic tests normal
- Toxicology screening negative
- Phenytoin level cancelled
- Diagnoses:
 - AMS
 - Status Epilepticus
 - Respiratory Failure

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Family Arrives, Pt History

- Pt with history refractory seizures
- Hx carotid artery occlusion R
- Due for carotid endarterectomy
- Phenobarbital & dilantin, compliant
- Prior history of SE treated at UIC
- No recent illness, trauma, EtOH
- No medic alert bracelet

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Patient Outcome

- EEG in ED, within 150 minutes
- Neuro consultation, no subtle SE
- Admit to Neuro ICU
- Repeated doses of rocuronium
- Final disposition for carotid Rx

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Conclusions

- Status epilepticus: medical emergency
- Few hospitals utilize a SE protocol
- SE protocol improves patient outcome
- Guidelines exist that facilitate practice
- New useful medications exist
- SE provides a model for all AED use

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Questions?

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