GUIDELINE FOR PHARMACOLOGIC MANAGEMENT OF ACUTE AGITATION IN PEDIATRIC PATIENTS

CHILD HEALTH BC
LEAD BENEFACTOR save on foods

Apply non-pharmacologic strategies **first**

Moderately agitated behavior: Start at Step 1

Severely agitated behavior: Start at Step 2

DIAGNOSIS	STEP 1	STEP 2	STEP 3
	• Review subsequent pages for potential contraindications, precautions, and alternative medications. • If no response after 30-60 min (PO) or 15-30 min (IM), move to the next step. **Note:** If partial response, consider repeat dose or dose escalation before moving to next step.		If Step 2 was not effective, consider internal or external consult or transfer to higher level of care
Substance intoxication or withdrawal	lorazepam PO/SL	lorazepam PO/SL/IM*	lorazepam PO/SL/IM* + loxapine PO/IM
Delirium	risperidone or loxapine PO	repeat previous or loxapine IM or haloperidol IM/IV	haloperidol IM/IV + diphenhydramine IM/IV +/- lorazepam PO/SL/IM*
ADHD, ODD, conduct disorder, neurodevelopmental disorder, or autism **Unknown etiology < 12 years old**	risperidone, chlorpromazine, quetiapine, or loxapine PO	antipsychotic (repeat previous or loxapine IM) + lorazepam PO/SL/IM*	
Anxiety, trauma, PTSD, or eating disorder **Unknown etiology ≥ 12 years old**	lorazepam PO/SL	lorazepam PO/SL/IM* + loxapine PO/IM	

*lorazepam can also be given IV in critical care

If any signs of EPS or dystonia occur after an antipsychotic medication, give benztropine or diphenhydramine (see medication table for details)

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