**Viewpoint**

By Mark L. DeBard, MD

It is not often in a modern physician’s career that a new disease, syndrome, or pathological process is described or recognized. It requires significant expert consensus to achieve this. But that consensus was recently reached for Excited Delirium Syndrome (ExDS).

ExDS is a real and unique syndrome, and that groundbreaking conclusion was released by the ACEP Excited Delirium Task Force in a white paper at the recent Scientific Assembly of the American College of Emergency Physicians. The task force, appointed by the 2008 ACEP Council, consisted of 18 expert emergency physicians and one PhD researcher. Only medical examiners had previously recognized ExDS, and because other specialties rarely come in contact with these patients, it is unlikely other groups will recognize it for many years.

Recognition by ACEP expands the description of this syndrome beyond the scope of the medical examiner and brings it into the realm of prehospital and emergency department care. It newly recognizes that there are nonfatal as well as fatal cases, and suggests that fatal cases are only eight percent to 14 percent of all cases.

Importantly, ExDS is noted to be identifiable by a distinctive group of clinical and behavioral characteristics, a triad of delirium, psychomotor agitation, and physiologic excitation, with between six and 10 separately identifiable characteristics. This cluster of symptoms typically occurs in the setting of acute or chronic stimulant abuse or, less commonly, serious mental illness. It is suggested that the syndrome, while currently of indefinite cause, may be amenable to early therapeutic intervention, which should include avoiding physiologic stress to the degree possible, the provision of immediate sedative medication, and supportive care.

The report has some political implications, too, because it rejects the theory that ExDS is an invented syndrome being used to cover up excuse the use of force or even brutality by law enforcement officers when some deadly force was used.

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Mash leads the effort to define the pathophysiology of the brain in fatal cases, currently connected to malfunction of the dopamine transporter system with a possible genetic predisposition. What we also need are published clinical descriptions of nonfatal cases to expand our knowledge of the syndrome and to allow for research into these cases. Emergency physicians need to recognize patients brought to them or who otherwise develop the syndrome during care so that the primary suggested treatments of reduction of physiologic stress and provision of sedation can be immediately started. These cases should then be recorded and published, perhaps through an online database. Through these efforts, we can define the best strategies for intervention in all environments and identify methodologies to save more lives.

in their custody. It rejects the idea that specific forms of restraint in and of themselves are what cause deaths in ExDS patients. Instead, ExDS is a potentially fatal disease in which all forms of physiologic stress, from physical and noxious chemical to electrical conductive weapons (commonly called TASERs), can tip the balance of a condition on the edge of being fatal. It recognizes that some form of the use of force will often be necessary to control agitation in the face of delirium, but that it should be the minimal amount necessary to achieve patient control and ensure public safety, and be followed immediately by medical intervention.

Law enforcement officers and emergency medical system providers are urged to be alert for this medical syndrome and to support the development of rapid treatment protocols similar to what six large EMS systems currently do, including my own city of Columbus, OH.

This report, while important, is merely a beginning to the research needed into this syndrome. Dr. Deborah DeBard is a professor of emergency medicine at Ohio State University College of Medicine, an attending emergency physician at Ohio State University Hospital East, and a past speaker and board member of the American College of Emergency Physicians.

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many things focusing on two major topics: cool stuff and bad stuff. The more I fly and the more people I talk to who have gray hair, the more I realize that reading the bad stuff provides me with the motivation to become a better pilot and to never make the bad-stuff list. Having been in an airplane for 6000 hours with an instructor and almost bringing in a plane landing gear up, I’ll share with you two of my favorite adages from flying that might be applicable to medicine.

There are two types of pilots: those who have landed gear up and those who will, and there are old pilots and bold pilots but never both.

I always use a checklist. I still make mistakes, but far fewer now that I programmed the checklist into my GPS, which I can’t use until I complete the list. When Dr. Leap and I fly together, and as we approach the concrete at 100 miles an hour, I suspect he will quickly appreciate, in real terms, what the difference is between having no list, a paper list, an electronic list, and positive feedback with cockpit resource management (CRM).

There are some other cool concepts