A case of severe emergence agitation in the post-operative care unit in a child with lost intravenous line

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A Case of Severe Emergence Agitation in the Postoperative Care Unit in a Child with Lost Intravenous Line
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Introduction

We describe a case of management of emergence agitation in a nonverbal developmentally delayed anxious child without an intravenous line in the postoperative care unit (PACU).

Case description

A 6 year old, morbidly obese, 77 kg male, non-verbal with developmental delay and autism presented for resection of in-growing toe nail. He had oral midazolam preoperatively and was cooperative for inhalational induction with nitrous oxide, oxygen and sevoflurane. After securing an intravenous (IV) line after induction, laryngeal mask airway (LMA) was placed and anesthesia was maintained with sevoflurane, fentanyl and local digital block. Propofol was administered pre-emptively for emergence agitation at the time of removal of the LMA under deep anesthesia. Patient became combative in PACU and IV was lost. Emergence agitation was successfully managed with intramuscular lorazepam and haloperidol.

Assess the patient for potentially dangerous causes of agitation in PACU

Hypoxia, Hypoglycemia, Pain, Hypercarbia

Factors of unproven benefit in the management of emergence agitation

1. Parental presence
2. Midazolam
3. Dexmedetomidine PO

Management of emergence delirium in a patient with lost IV in PACU

1. IM Benzodiazepines, Lorazepam/Midazolam
2. IM Haloperidol
3. IM Dexmedetomidine
4. Induction of general anesthesia and insertion of IV

Deep removal of LMA vs awake extubation of endotracheal tube

The incidence of emergence agitation is lower when LMA is removed deep compared to awake extubation of an endotracheal tube anesthesia.

Conclusion: In the absence of an IV in our case, we successfully managed emergence agitation with intramuscular lorazepam and haloperidol.

References: