Considerations for the Care of Children with Autism in the ED

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Grand Rounds PEM Oct 16 2019

Diagnosis of Autism Spectrum Disorder (DSM 5 Criteria):
Persistent deficits in social communication and social interaction across multiple contexts as manifested by **all three**:

- Deficits in reciprocity
- Deficits in non-verbal communication
- Deficits in skills in developing, understanding and maintaining relationships

AND requires presence of restricted, repetitive patterns of behavior, interests or activities (*at least two*)

- Stereotyped movements or speech
- Insistence on sameness, routines or ritualized patterns
- Highly restrictive, fixated interests that are abnormal in focus
- Hyper/hypo reactivity to sensory aspects of environment

Specifiers**(*diagnosis of ASD does not automatically signify an intellectual impairment*)
+/- Intellectual impairment, +/- Language Impairment
+/- Associated with known medical/genetic condition

Asperger's = ASD without language or intellectual impairment

Presentation:

- Very heterogeneous in presentation
- Signs typically evident by three years old
- Can have regression of previously achieved skills before age of two years old
- ***Adaptive learning occurs throughout life***

Prevalence:

- 1/52 children in BC
- Boys >> Females 4.5x

Diagnosis: Through BC Autism Assessment Network or private

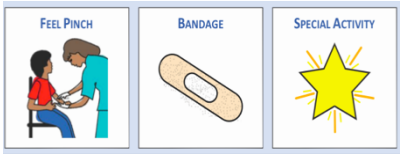
- Current wait time in BC **59.8 weeks**
- Priority given to children under 6 years old

An Approach to ED visits – Key Points

1. Develop an awareness of specific individual needs of child and how best to meet those needs by involving the caregiver early and in each step
2. Minimize triage time → early triage to a quiet room with minimal sensory stimuli
3. Consider transition points in ED stay (testing/ radiology) and plan and prepare with caregiver
4. Minimize amount of different health care provider encounters if possible
5. Use targeted questions:
    - What are your child's triggers?
    - What reduces stress and how can we improve stress?
    - What sensory does you child find calming?
    - Is your child sensitive to touch, sound, light or movement?
    - How does your child communicate pain?

Tools and Strategies:

- Triage "My ED Plan" filled out by parents
- Procedure based story books
- Adjunct communication tools such as text-messaging
- First-Then Boards for Procedures (available online)



Common Presentations:

- Majority of children with ASD present with a true medical complaint
- 2x the admission rate compared to general population
- Epilepsy present in 25-39% of children with ASD
- Most children have some ongoing GI symptom (70%)
- Higher incidence of ***Dental issues, Sleep Disorders***, ***Self Injury*** and ***Toxologic Exposures*** compared to general population

Procedural Sedation:
Remain flexible, allow choice, practice with child-life before beginning and use concrete language
Therapeutic communication de-escalation first line

- Environmental Adaptation
- Rewards/Incentives
- Sensory interventions – heated/ weighted blankets
- Block instead of restraints (try pillows or blanket wrap)

Acute Agitation:

Drug	Dose	Adverse Effect
Anxious Agitation		
Lorazepam	**< 12 years or < 50 kg:** 0.5-1 mg/dose max 4 mg/24 hours **13-17 years or > 50 kg:** 1-2 mg/dose max 8 mg/24 hours (*0.05-0.1 mg/kg/dose*)	Sedation, postural hypotension, bradycardia, paradoxical reaction
Moderate Agitation		
Olanzapine	**< 12 years or < 50 kg**: 1.25-0.5 mg/dose max 10 mg/24 hours **13-17 years or > 50 kg:** 2.5-5 mg/dose max 20 mg/24 hours (*0.03-0.07 mg/kg/dose q6h PRN*)	Sedation, EPS, QT prolongation
Risperidone	**< 12 years or < 50 kg:** 0.25-0.5 mg/dose q6h max 2 mg/24 hour **13-17 years or > 50 kg**: 0.5-1 mg/dose q6h max 4 mg/24 hours	Sedation, EPS, QT prolongation
Severe Agitation		
Loxapine	**< 12 years or < 50 kg:** 6.25-12.5 mg/dose max 50 mg/24 hours **13-17 years or > 50 kg:** 12.5-25 mg/dose max 100 mg/24 hours	Sedation, EPS

Pharmacological Agents:

- Limited studies – most show success with ketamine and/or midazolam with minimal adverse effects

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Agitation

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