Status Epilepticus Clinical Pathway

0-5 min

1.ABC**DEFG** (**D**on't **E**ver **F**orget the **G**lucose)
2. Airway: Lateral decubitus, Nasal trumpets, O2, Suction
3. IV Access
4. Search for reversible causes (see special considerations)

Consider initiation of first line Tx with benzodiazepines prior to waiting 5 minutes

5-15 min

First line agents (repeat q5 min up to 2 doses):

IV Lorazepam 4 mg and up to 0.1 mg/kg;
OR
Midazolam 10 mg IM once (If no IV access)
OR
IV Diazepam: 10-20 mg

Consider giving second line agent in tandem with second dose of benzodiazepine

Consider Intubation if needed

15-30 min

Second Line Agents:

Levetiracetam 60 mg/kg IV (max 4500 mg)
OR
Fospheytoin or Phenytoin 20 mg/kg IV (max 1500 mg)
OR
Valproate 40 mg/kg IV (max 3000 mg)

Medications in refractory status epilepticus

Propofol: 2-5 mg/kg IV, then infusion of 2-10 mg/kg/hr
Midazolam: 0.2 mg/kg IV, then infusion of 0.05-2 mg/kg/hr
Ketamine: 0.5-3 mg/kg IV, then infusion of 0.3-4 mg/kg/hr
Phenobarbital: 15-20 mg/kg IV at 50-75 mg/min

Advanced airway management:

RSI
Preoxygenation: BVM
Induction: Propofol (1-2.5 mg/kg IV), Ketamine (1-2 mg/kg IV or 4-6 mg/kg IM), or Ketofol (1:1 mixture, 0.5-1.0 mg/kg IV of each)

Special considerations:

- Always consider toxicologic causes (avoid phenytoin or fosphenytoin in undifferentiated tox patient or drug withdrawal due to Na channel blockade)
- Consider POC Chem8 if available in new onset seizures to evaluate for hyponatremia
- Give thiamine and glucose if hypoglycemic or known alcoholic
- Consider nonconvulsive status epilepticus in known epileptic patient without return to baseline → Emergent EEG, consider benzos