**Summary of Acutely Depressed Mental Status in Children**

**Etiology**

* Broad differential, manageable in categories
* Differentiate symmetric from asymmetric presenting signs
	+ Symmetric: Toxins, Drugs, Metabolic, Infections, Primary Neuro/Epilepsy. Structural etiology less common in this group, but includes bilateral lesions and large insults
	+ Asymmetric: Structural etiology more common in this group, aim to localize the lesion

**Initial Work Up**

* Vitals, cardio-respiratory, focused general and neuro exams
* Glascow coma score
* Consider initial screening labs: CBC, chemistries, LFTs, bedside glucose, UA, urine tox screen, blood culture, blood gas
* Head CT scan is the initial imaging test of choice, obtain stat if head trauma, focal neurologic signs or evidence of increased ICP (can consider stat MRI if available)
* Lumbar puncture: obtain if no signs of increased ICP and if signs of infection or if diagnosis unclear

**If Etiology Remains Elusive**

* Other laboratory tests: workup for metabolic conditions, coagulation studies, specific toxins
* EEG to rule out non-convulsive status epilepticus
* Brain MRI with DWI

**Initial Management**

ABCs/PALS:

* Intubate for GCS ≤8

Empiric therapy:

* 2.5 mL/kg of 10 % IV dextrose solution, do not delay pending return of blood glucose results
* If clinical seizures
	+ Treat with lorazepam 0.1 mg/kg IV, max 5 mg
* If concerned for possible ingestion:
	+ Opiates suspected: Naloxone 0.01 mg/kg IV, repeat Q2 min up to max of 0.1mg/kg or 2mg
	+ Other antidote based on history / clinical suspicion (e.g. physostigmine for anticholenergic overdose)
* If concerned for possible infection:
	+ Can treat with Ceftriaxone at meningitic doses and Vancomycin
	+ Acyclovir
* If concerned for possible non-convulsive status epilepticus:
	+ Can treat with lorazepam 0.1 mg/kg IV, max 5 mg
	+ Fosphenytoin (15 to 20 Phenytoin Equivalents/kg) IV loading dose
* If concerned for possible increased ICP:
	+ Mannitol 0.5 to 1 gram/kg IV