ACMT Position Statement:
End the Use of the Term "Excited Delirium"

May 1, 2023

Authors: Andrew I. Stolbach, MD, MPH, FACMT; Paul I. Dargan, MB, BS, FACMT; Howard A. Greller, MD, FACMT; Richard J. Hamilton MD, MBA, FACMT; Kelly Johnson-Arbor, MD, FACMT; Brian Patrick Murray, DO; Daniel Ovakim, MD, MSc, FACMT; Laura Tormoehlen, MD, FACMT; and Lewis S. Nelson MD, MBA, FACMT

Collaborators: Sukhshant Atti, MD; Jeffrey N. Bernstein, MD, FACMT; Caitlin Bonney, MD, FACMT; Jeffrey Brent, MD, PhD, FACMT; Ron Kirschner, MD; Mehruba Anwar Parris, MD, FACMT; Michael Simpson, MD; Christian Tomaszewski, MD, MS, FACMT; Brandon J. Warrick, MD; Stephanie T. Weiss, M.D., PhD; and Amy C Young, MD

The position of the American College of Medical Toxicology (ACMT), is as follows:

Medical toxicologists are experts in clinical pharmacology and the management of critically ill undifferentiated patients who may be intoxicated with psychoactive substances. We also have expertise in the selection and interpretation of drug testing in the medicolegal death investigation. The term "excited delirium" was first used to describe agitated patients with cocaine toxicity and later as a cause of death in hyperactive individuals where autopsy failed to identify a more specific lethal medical or traumatic cause. Because the term "excited delirium" is used in multiple distinct contexts with various underlying causes, and has become associated with racism, it is time to discontinue the use of this term. The term "hyperactive delirium with agitation" more accurately describes the undifferentiated presentation of patients with disorientation who appear aggressive or have vital signs suggestive of excessive adrenergic activity. When possible, the underlying cause of death should be listed on the death certificate.

"Excited Delirium" as a Clinical Diagnosis

Although severe agitation has been described with various terms in the medical literature, the term "excited delirium" (or "excited delirium syndrome," or "agitated delirium") was first used in medical literature in the 1980s in reference to agitated individuals with cocaine toxicity [1,2]. The term "excited delirium" has historically been used as a descriptor in two distinct settings: The presentation of an agitated, disoriented patient (in the prehospital or hospital setting) and ascribed as a cause of death in patients with a constellation of manifestations related to agitation and hyperthermia.

Since the mid-1980s, the term has been broadly used and is cited as a rationale for restraint and sedation by law enforcement officers [3]. It is used in forensic pathology but is not defined based on autopsy and forensic laboratory analysis and its determination may depend on the accounts of non-

medical personnel [4,5]. The scientific literature does not support the existence of a unique “excited delirium” syndrome. The World Health Organization International Classification of diseases, and the American Psychiatric Association’s Diagnostic and Statistical Manual 5th edition (DSM-5) do not recognize “excited delirium” as a formal diagnosis [6,7]. In 2009, the American College of Emergency Physicians (ACEP) task force white paper concluded that Excited Delirium Syndrome “is a real syndrome of uncertain etiology” [8]. However, in 2021, an ACEP task force revisiting the issue used the term “hyperactive delirium with severe agitation” to describe this presentation, not “excited delirium” [9].

“Excited Delirium” and the Death Investigation

“Excited delirium” has been documented as a cause of death following “delirium involving violent behavior” when autopsy “fails to detect a disease or physical injury that has an extent or severity to explain the death” [4]. As currently used, “excited delirium” describes observed signs and symptoms produced by a number of other underlying etiologies. Unexpected deaths in patients exhibiting delirium with agitation have been associated with decreased ventilation and acidosis related to restraint or prone positioning, as well as cardiomyopathies and channelopathies [3,10,11]. The subjective interpretation of the term “excited delirium” may falsely suggest that preventable in-custody deaths are inevitable outcomes. We do not believe that the term used to describe an initial undifferentiated clinical presentation - whether this be “excited delirium” or “hyperactive delirium with agitation” - should be used as a cause of death. Like the term “cardiac arrest” (which is typically not acceptable on death certificates) these terms simply describe symptoms and signs and do not refer to or identify the cause of the deterioration and the patient’s death. If the inciting etiology of delirium is identified, then this should preferentially be listed as the cause of death. This approach, endorsed by the National Association of Medical Examiners [12], allows for more precision and clarity in fatality data.

Major Medical Groups Call to Stop Use of the term Excited Delirium

The term “excited delirium” has been used disproportionately in law enforcement-related deaths of Black individuals [3,13,14]. Based on these observations and others, the American Medical Association opined that the term has been associated with racism in medicine and law enforcement [15]. ACMT joins other organizations, including the American Psychiatric Association [16], American Academy of Emergency Medicine [17],American Medical Association [15], UK Royal College of Emergency Medicine [18], UK Forensic Science Regulator and Royal College of Psychiatrists [19], and the UK Royal College of Pathologists [20] who have all called to abandon the term “excited delirium” as a diagnosis and a cause of death.

Clinical Presentation

Whatever terminology is used, patients presenting with delirium and agitation represent an acute medical emergency. Agitation is a frequent outwardly visible component of hyperactive delirium; one that may draw the attention of law enforcement or members of the public before presentation for medical care.

In the acute setting, such presentations may be caused by stimulant use, drug withdrawal, behavioral, infectious, metabolic, endocrine, or other medical conditions, alone or in combination. The differential diagnosis of these patients is broad. Regardless of the cause, hyperthermia, acidosis, and/or dysrhythmia may result in death if not discovered and treated promptly and properly.

The Term “Hyperactive Delirium with Agitation”

Although we support discontinuing use of the term “excited delirium,” we believe that it is useful to have terminology describing the clinical condition of a patient with dangerous psychomotor hyperactivity and agitation while the final etiology and diagnosis are being determined. We prefer the term “hyperactive delirium with agitation” to describe this initial undifferentiated presentation of patients with altered mental status who are aggressive or have vital signs suggestive of excessive adrenergic activity. “Hyperactivity,” “delirium,” and “agitation” are clear and established medical terms.

“Delirium” describes an acute decline in cognition, fluctuating over hours to days, characterized by a deficit of attention. Hyperactive delirium is already recognized as a subtype of delirium, distinguishing the presentation from hypoactive delirium with psychomotor slowing [21]. Moreover, the term “hyperactive delirium with agitation” does not have the problematic history of “excited delirium.”

The management of patients with hyperactive delirium with agitation should include behavioral de-escalation techniques and will often require the use of sedative medications with the goals of protection of both patient and caregivers, and for the facilitation of further diagnosis. The use of physical restraints should be minimized and discontinued as early as possible.

Disclaimer

While individual practices may differ, this is the position of the American College of Medical Toxicology at the time written, after a review of the issue and pertinent literature.

References

1. Fishbain DA, Wetli CV. Cocaine intoxication, delirium, and death in a body packer. Ann Emerg Med. 1981 Oct;10(10):531-2. doi: 10.1016/s0196-0644(81)80010-8. PMID: 7283219.
2. Wetli CV, Fishbain DA. Cocaine-induced psychosis and sudden death in recreational cocaine users. J Forensic Sci. 1985 Jul;30(3):873-80. PMID: 4031813.
3. Grant JR, Southall PE, Mealey J, Scott SR, Fowler DR. Excited delirium deaths in custody: past and present. Am J Forensic Med Pathol. 2009 Mar;30(1):1-5. doi: 10.1097/PAF.0b013e31818738a0. PMID: 19237843.
4. Gill JR. The syndrome of excited delirium. Forensic Sci Med Pathol. 2014 Jun;10(2):223-8. doi: 10.1007/s12024-014-9530-2. PMID: 24526411.
5. Slocum S, Fiorillo M, Harding E, Owen J, Long R, Dunn T, Martin I. In pursuit of inter-specialty consensus on excited delirium syndrome: a scoping literature review. Forensic Sci Med Pathol. 2022 Nov 9. doi: 10.1007/s12024-022-00548-4. Epub ahead of print. PMID: 36350497.
6. American Psychiatric Association. (2022). Neurodevelopmental disorders. In Diagnostic and statistical manual of mental disorders (5th ed., text rev.)
7. World Health Organization. International classification of diseases 11th edition. https://icd.who.int/en.
8. American College of Emergency Physicians. White paper report on excited delirium. September 9, 2009. https://www.prisonlegalnews.org/media/publications/acep_report_on_excited_delirium_syndrome_sept_2009.pdf
9. ACEP Hyperactive Delirium Task Force. ACEP Task Force report on hyperactive delirium with severe agitation in emergency settings.https://www.acep.org/globalassets/new-pdfs/education/acep-task-force-report-on-hyperactive-delirium-draft-.pdf)
10. Karch SB. Possible Strategies for the Diagnosis of Fatal Excited Delirium Syndrome. Academic Forensic Pathology. 2012;2(3):273-283. doi:10.23907/2012.040

11. Pollanen MS, Chiasson DA, Cairns JT, Young JG. Unexpected death related to restraint for excited delirium: a retrospective study of deaths in police custody and in the community. CMAJ. 1998 Jun 16;158(12):1603-7. PMID: 9645173; PMCID: PMC1229410.
12. National Association of Medical Examiners. Excited Delirium Statement 3/2023 https://name.memberclicks.net/assets/docs/Excited%20Delirium%20Statement%203%20-%202023.pdf
13. Stratton SJ, Rogers C, Brickett K, Gruzinski G. Factors associated with sudden death of individuals requiring restraint for excited delirium. Am J Emerg Med. 2001 May;19(3):187-91. doi: 10.1053/ajem.2001.22665. PMID: 11326341.
14. Gonin P, Beysard N, Yersin B, Carron PN. Excited Delirium: A Systematic Review. Acad Emerg Med. 2018 May;25(5):552-565. doi: 10.1111/acem.13330. Epub 2017 Nov 27. PMID: 28990246.
15. American Medical Association. New AMA policy opposes “excited delirium” diagnosis. June 14, 2021. https://www.ama-assn.org/press-center/press-releases/new-ama-policy-opposes-excited-delirium-diagnosis.
16. American Psychiatric Association. Position statement on concerns about use of the term excited delirium and appropriate medical management in out-of-hospital contexts.https://www.psychiatry.org/about-apa/Policy-Finder/Position-Statement-on-Concerns-About-Use-of-the-Te
17. American Academy of Emergency Medicine. AAEM excited delirium statement.https://www.aaem.org/UserFiles/RevisedAAEMExcitedDelirium9.21.22.pdf
18. Royal College of Emergency Medicine. Acute behavioral disturbance in emergency departments. https://rcem.ac.uk/wp-content/uploads/2022/09/Acute_Behavioural_Disturbance_in_Emergency_Departments_Sep2022_V2.pdf
19. Royal College of Psychiatrists.’Acute behavioral disturbance’ and ‘excited delirium.’ https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps02_22.pdf?sfvrsn=63c6bcdc_6
20. Forensic Science Regulator, Royal College of Pathologists. Forensic Science Regulator Guidance: The Use of ‘Excited Delirium’ as a Cause of Death. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/929746/Excited_Delirium_Guidance_2.pdf
21. Josephson S, Miller BL. Confusion and Delirium. In: Loscalzo J, Fauci A, Kasper D, Hauser S, Longo D, Jameson J. eds. Harrison’s Principles of Internal Medicine, 21e. McGraw Hill; 2022.