Status epilepticus is defined as a seizure that lasts for > 30 minutes or recurrent seizures without full recovery between seizures for > 30 minutes. A child who has been convulsing for > 5 minutes should be treated as for status epilepticus.

### Manage ABCs
- Cardiac monitor; oximeter
- Establish IV access
- Place in the recovery position

### Attempt IV
- IV lorazepam 0.1 mg/kg over ½ - 1 min (max 4 mg)
- OR
- IV diazepam 0.3 mg/kg over 2 mins (max 5 mg in infants and 10 mg in child)
- OR
- IV midazolam 0.1 mg/kg over 2-3 minutes (max 8 mg)

Benzodiazepine can be repeated once after 5 mins.

### Rapid IV Access obtained?
- Yes
- No

### Rapid IV
- Repeat IV lorazepam 0.1 mg/kg over ½ - 1 min (max 4 mg)

### Rectal midazolam
- 0.2 mg/kg  (max 10 mg/dose)
- For IN max 5 mg/nostril
- Or
- Rectal diazepam 0.5 mg/kg/ (max 10 mg)

Benzodiazepine can be repeated once after 5 mins.

### Insert intraosseous needle if seizure is not stopped with rectal benzodiazepine

### Is child on phenytoin?
- Yes
- No

### IV/IO phenytoin 20 mg/kg over 20 mins
- Or
- IV/IO phenytoin 10 mg/kg in NS over 20 mins. (max 750 mg)

Give phenytoin on phenobarbital after the first dose of benzodiazepine unless febrile and the seizure has stopped.

### IV/IO access not available or tenuous:
- IM Fosphenytoin 20 mg phenytoin equivalents (PE)/kg (max 1000 mg PE)

### Seizure stopped?
- Yes
- No

### Admit to hospital, investigate and treat potential causes of status epilepticus.

### Rapid Sequence Intubation

### Rectal Paraldehyde: If available, can be administered prior to Phenytoin or Phenobarbital
- 0.3 to 0.5 ml/kg in same volume of mineral oil to a maximum of 10 ml

### IV/IO midazolam
- 0.1 mg/kg loading dose (max of 8mg) over 2-3 minutes
- Then
- 120 ug/kg/hour infusion
- Increase by 120 ug/kg/hour every 5 minutes if the seizure continues
- Maximum 900 micrograms/kg/hour

### Further Management After Cessation of Seizure:
- Obtain further history
  - Recent trauma, infection, ingestion, drug history, seizure history
- Further investigations:
  - (as indicated by clinical presentation and history if not done on initial presentation):
    - Blood culture
    - Blood gas
    - Clotting studies, liver enzymes
    - Lumbar puncture (should be deferred until cessation of clinical seizure)
    - Imaging (CT head)
    - In selected patients:
      - Plasma: ammonia, lactate, amino acids
      - Urine: organic acids, toxicology
- Initiate appropriate therapy as indicated:
  - Empiric anti-meningitic dose of IV antibiotics and Acyclovir (in febrile patient without identified etiology)
  - Appropriate maintenance antiepileptic medications
- Admit to appropriate ward or ICU

### Notes:
- IV attempts should be limited to 3 tries or 90 seconds.
- Intraosseous needle should be inserted if IV attempts fail.
- Rectal Paraldehyde may not be practical due to large dose volume, requiring multiple IM injection sites.
- Rectal Paraldehyde, if available, can be administered prior to Phenytoin or Phenobarbital.
- Initial dosing of fosphenytoin may not be practical due to large dose volume, requiring multiple IM injection sites.