The ATLS protocol was followed with pressure dressings being applied to all the lacerations. Cervical spine immobilisation was considered but not recommended in view of his presentation and the likelihood of him becoming more noncompliant. His speech was incoherent and he had memory loss. He had a left lateral strabismus and noticeable bilateral horizontal nystagmus. He also had a tremor and had wide spaced ataxic gait.

He was uncooperative and spoke persistently. He calmed down a little when the hospital security and his sister arrived. At this point he allowed an examination and an intravenous cannulation. In this context all routine bloods tests were drawn including a venous blood gas and blood cultures and toxicology test. He was given intravenous 10mg of diazepam which made him more compliant and calm. He was also given 5mg of Haloperidol after a 12L ECG was normal with no prolonged QT.

His vital signs were 126/84 mmHg, Pulse of 118 bpm, Respiratory Rate of 20, Temperature of 37 Celsius and Blood Glucose of 4mmol/l.

Once complaint and reassured a CT brain and CT cervical spine were obtained and he had plain film x-rays of his chest and arms. A urine sample was also obtained for testing. All radiological tests were reported normal and his bloods tests showed normal renal functions; elevated CK of 20000; WBC of 11 Plts of 163 Hb 10.5g/dl and CRP of 100. A blood alcohol level was 0 and the toxicology screen was negative. He was subsequently started on fluids, antibiotics and Pabrinex (a combination of B and C vitamins). Once complaint he was admitted by the medical team and an LP was done to exclude an infective cause and this was followed up with a MRI brain. These results were normal.

**Management:**

His treatment plan followed acute trauma protocol with the context of an acute psychotic patient. He initially calmed a little with his sisters arrival and was given IV diazepam to sedate him further. He was further given IV Haloperidol for the psychotic symptoms. This combination allowed a thorough clinical examination and assessment. The ATLS approach to trauma was followed and pending investigations he was also immediately given IV antibiotics and an antiviral for a possible infective cause. These were stopped once normal results returned.

Diazepam regimen for detoxification, rehydration and high doses of thiamine were continued. The complex lacerations and Lis Franc injuries required specialist referrals. His condition improved remarkably 3 days after his admission and treatment with thiamine. The complete his assessment he also had a psychiatry review.

**Discussion and Conclusion:**

This situation poses a huge risk to both the patient, the staff and other patients in an overcrowded ED. It is even more complex when both trauma and other cause is suspected. The immediate approach should always be in the best interests of the patient. Both safety of patient and staff are paramount. In the event of such a mixed scenario it would be best to sedate and assess the patient. It would always be best to approach the patient a non aggressive calm manner and to engage meaningfully with them. Calm relatives also help. Whilst security might reassuring for the staff it may be interpreted as threatening by the patient. With increased migration language barriers are important to contend with early and an interpreter is an essential resource. The use of sedatives and antipsychotics should be judiciously considered and used in the clinical context. All primary investigations should be done immediately with the intent of finding the cause. This case highlights the situational awareness, medicolegal; ethical and clinical considerations that an ED doctor should be cognisant of in a case of WKS and other aggressive patients.

The assessment was based on the approach to a confused trauma patient which is multidisciplinary team approach which included the initial ED team, medical team and psychiatric teams.. His differential included head injury secondary to a fall, alcohol/ drug intoxication, infection and WKS. WKS is a rare but reversible and treatable condition which responds to timely intervention; rapid diagnosis and thiamine administration. This complex case underlines the need for good clinical history, examination and awareness of WKS in context.

**References:**