The Reemergence of Ketamine for Treatment in Critically Ill Adults

**Acute Pain Management**
Ketamine can reasonably be considered as an adjunctive agent for acute pain in ED (level 2 evidence)

Rates of fatigue, dizziness, nausea, feelings of unreality with ketamine

Dose: 0.1-0.5 mg/kg IV over 3-5 min OR 15 mg IV x 1 followed by 20 mg infusion over 60 min

**Analgesedation**
Consider ketamine as an adjunctive sedative for refractory mechanically ventilated patients as an opioid-sparing agent (level 3 evidence)

8% required discontinuation due to adverse events

Dose: 0.06-0.94 mg/kg/hr IV infusion

**Status Epilepticus**
Consider ketamine early in the setting of refractory SE especially in the setting of cardiac depression (level 3 evidence)

7% experienced arrhythmias and infusion-related reactions

Dose: 0.05 to 10 mg/kg/hr IV infusion ± 1.5 mg/kg initial IV bolus

**Status Asthmaticus**
Ketamine showed no significant efficacy compared to standard of care for status asthmaticus and should not be routinely used (level 3 evidence)

Adverse events 17.4% vs. 4.8% in standard of care, p = 0.1880

Dose: 0.1 mg/kg IV bolus over 5 min followed by 0.5 mg/kg/hr IV infusion

**Alcohol Withdrawal**
More evidence is needed on ketamine as an adjunct to AWS to determine appropriate timing, dosing, and monitoring (level 3 evidence)

Well tolerated, no patients required discontinuation of ketamine

Dose: 0.15-3 mg/kg/hr IV infusion ± 0.3 mg/kg initial IV bolus

**Acute Agitation**
Studies suggest ketamine may be used for acute agitation in the ED or pre-hospital setting, but more studies are needed (level 3 evidence)

High rate of intubation, hypersalivation, emergence reaction, laryngospasms

Dose: 0.25-0.5 mg/kg IV bolus followed by 1-2 mg/kg/hr IV infusion OR 3-5 mg/kg IM