



ELDER CARE

A Resource for Providers

Delirium in Elders

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Delirium, an acute, confusional state, is associated with high morbidity and mortality in the elderly. Seen most often in a hospital setting, delirium can occur in up to 30% of elderly hospitalized patients, and in up to 70% of elderly patients in the ICU. Delirium prolongs hospital stays, is associated with functional decline, and results in higher rates of nursing home placement. For these reasons, health personnel who take care of the elderly must work diligently to prevent the onset of delirium, learn to quickly recognize its symptoms and signs, and utilize an effective strategy for treatment.

Delirium remains a clinical diagnosis, which is one of the reasons it is often overlooked. The DSM –IV criteria for delirium include: (1) disturbed consciousness, (2) cognitive change, (3) rapid onset, and (4) evidence of a physical cause. Efforts to create a diagnostic tool for delirium have led to the use of the CAM, or Confusion Assessment Method. There are four diagnostic criteria in the CAM; the first two must be present plus at least one of the third and fourth: (1) acute onset of change in mental status, or rapid fluctuations, (2) inattention, (3) disorganized thinking, (4) altered level of consciousness.

Conditions that can precipitate the onset of delirium are myriad. Several medications are known to be risk factors for the development of delirium. Any cognitive deficit, whether from stroke, Alzheimer's type de-

mentia, or Parkinson's disease, for example, can predispose a patient to delirium. Visual impairment, dehydration, and severe illness also increase the risk. The major causes of delirium in the elderly include infection, metabolic disorders, drug and alcohol use, and side effects from medication.

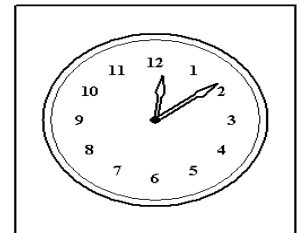
A clinician should begin by looking for treatable causes – evaluate for hypotension, hypoxia, infection, and urinary retention. Check a complete metabolic panel, blood alcohol level, and review medications. Further testing, including a head CT, lumbar puncture and/or EEG should follow if a treatable cause is not identified.

While there are several forms of delirium, elderly patients most often present in an hypoactive state. An agitated delirium is a true medical emergency; standard therapy remains 0.25-0.5 mg haloperidol IM with a max dose of 5 mg/24hours. Physical restraints can worsen symptoms and should be avoided. An elderly inpatient can benefit from simple prevention techniques, including: frequent reorientation, early mobilization, adequate lighting, good sleep hygiene, and use of all assistive devices from spectacles and hearing aids to dentures and walkers.

Ways to Prevent and Treat Delirium



Maximize Hearing and Vision



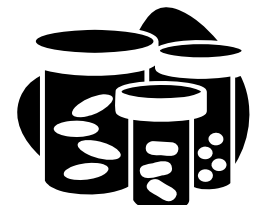
Frequent Reorientation



Treat Disease



Emphasize Mobility



Streamline Medications

Delirium—Points to Remember

- Don't accept "altered mental status" or "confusion" as a diagnosis; look for the delirium syndrome in your elderly patients.
- Don't forget hypoactive delirium is the most common form of delirium in the elderly.
- Delirium is a common presentation in the elderly for common medical problems. Rule out infection, hypoxemia, hypoglycemia, urinary retention, acute myocardial infarction, and stroke.
- Drugs, drugs, drugs! Evaluate medication schedule, dosages and side effects, particularly anticholinergic properties— Remember to ask about traditional medicines, over the counter medications, and drug and alcohol use.
- Prevention is far easier than treatment. Helpful and simple environmental measures can prevent episodes of delirium.
- Frequent visits and family support can further help to orient an elderly patient.

Medications & Delirium

Anticholinergic Side Effects

Anticholinergics
Antihistamines
Antipsychotics
Antispasmodics
Cyclic antidepressants
Mydriatics

Traditional Medicines

Burdock root
Black henbane
Atropa belladonna
Mandrake
Jinsom weed
St. John's Wort
Valerian

Other

Hypoglycemics
Hypnotics
Benzodiazepines
Antiarrhythmics
Beta blockers
Diuretics
Digoxin
Clonidine
Methyldopa
Dopamine agonists
Corticosteroids
Muscle relaxants
Anticonvulsants
Antiemetics
H-2 receptor blockers
Many antibiotics
Many antifungals

Looking at the CAM

Acute Change or Fluctuation in Mental Status—Assess by history and observation. Staff and family can attest to the admission/pre-op or pre-hospital cognitive status of the patient. Any acute confusional state should make the clinician consider delirium.

Inattention—Is the patient able to answer a direct question with an appropriate answer? Can the patient stay “on track” in normal conversation? If the answer is no, also look for fluc-

tuations in levels of attention, which can further signal delirium.

Disorganized Thinking—Is the patient's speech/thought process rambling, unclear, unpredictable, illogical, and/or irrelevant?

Altered Level of Consciousness—Assess the patient for alertness, vigilance, lethargy, stupor, or coma. All of the above can indicate the **different types of delirium:**

Agitated Delirium: A patient who is restless, picking at bedclothes, and whose behavior is detrimental to his own well-being and safety as well as that of the staff.

Hypoactive Delirium: A patient who demonstrates sluggishness and/or psychomotor retardation, often mistaken for depression or fatigue.

Mixed: A combination of both agitated and hypoactive delirium.

Delirium Versus Dementia

Dementia is a chronic, progressive, gradual, and irreversible change in cognitive function. There is no lab test for dementia, but tests of cognitive function over time (e.g. MMSE) can help to determine the rate of decline. Medications presently available for dementia merely slow the progression of the disease and are not curative.

Delirium is an acute, fluctuating, and reversible change in cognitive function. Again, there is no specific lab test, but a thorough assessment of the

patient's medical status is essential for identifying an etiology. Formal cognitive tests such as the MMSE can help to determine improvement as the delirium clears.

Often a previously undiagnosed cognitive deficit becomes more apparent after an episode of delirium. Families often note that the patient is just “not the same” after a hospitalization or a surgery.

???? Did You Know ????

The word “dementia” comes from the Latin meaning “out of mind,” whereas, the word “delirium” means “out of the furrow,” or “off the track.” Therefore, the very word delirium implies reversibility. Your goal as care provider is to get your patient “back on track” by careful clinical assessment and med review.

References

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