

Beware of Delirium

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ABSTRACT

Delirium has become one of the highest cost burdens to health care today. This preventable illness is underrecognized within acute and long-term health care settings. Providers need to be aware of the risk factors for developing delirium as well as the significance delirium has on patients and their families. Often, delirium is mistaken as dementia or depression; therefore, providers need to understand how to identify symptoms associated with each. Education and implementing screening tools into care can help clinicians identify delirium early, in turn preventing progression and saving the patient, family, and health care facility time, money, and heartache.

Keywords: Confusion Assessment Method, delirium, dementia, depression, Neelon and Champagne Confusion Scale, prescription medication, Richmond Agitation Sedation Scale

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Delirium affects between 10% and 24% of the hospital patient population, with the incidence increasing by the complexity of illness.¹ Delirium's reach can be vast, affecting as many as 60% of elderly patients, 60% to 80% of those admitted on a medical critical care unit, and up to 80% to 90% of those with terminal cancer.¹ Yet, delirium is often overlooked, goes unrecognized, or is misdiagnosed as an illness with similar symptoms, which can lead to significant problems.¹ Delirium is a state of impaired mental function characterized by a disturbance of consciousness.¹ It can present as either mild disorientation characterized by poor memory or as being easily distracted.

This article endeavors to investigate the causes and frequency of delirium. Clinical presentation, risk factors, and medications that may contribute to the presence of delirium are discussed. An investigation of screening for delirium as well as management, prevention, and prognosis are examined.

CAUSE AND FREQUENCY

Potential causes of delirium include inadequate pain control, drug or toxin, metabolic disturbances, neurologic conditions, psychotic disorders, a neurovascular insult, systemic organ failure, or a complication from a systemic illness.² The acronym "I WATCH DEATH" (Infectious, Withdrawal, Acute metabolic, Trauma, Central nervous system disease, Hypoxia, Deficiencies, Environmental, Acute

vascular, Toxins/drugs, Heavy metals) is used to help identify potential causes of delirium.³ Most patients are particularly prone to medication-induced delirium because there are a number of contributory medications. Medication-induced delirium is observed in both hospitalized and nonhospitalized patients.

In addition, those who experience delirium may also exhibit adverse effects, such as aspiration, loss of independence, or decreased mobility. Although delirium frequently goes unrecognized in hospital settings, about 20% of all patients 65 years and older are affected.¹ When delirium is not recognized in a hospital setting, patients often face extended stays, increased complications, higher transfer rate to nursing homes, and more dependence on care after discharge.

DIFFERENTIAL DIAGNOSIS

Because delirium is often misdiagnosed as dementia or another type of acute confusion, treating it requires determining the underlying cause of confusion. Generally delirium has more than 1 cause and may present as a hypo- or hyperactive state. These symptoms can mimic other medical conditions, most commonly dementia, depression, Alzheimer disease, or schizophrenia (Table 1).^{2,4}

CLINICAL PRESENTATION

The signs and symptoms of delirium appear over a shorter period of time, generally within a few days, as

Table 1. Differential Diagnosis

	Depression	Delirium	Dementia
Onset	Weeks to months	Hours to days	Months to years
Mood	Low/apathetic	Fluctuates	Fluctuates
Course	Chronic, responds to treatment	Acute, responds to treatment	Chronic, with deterioration over time
Self-awareness	Likely to be concerned about memory impairment	May be aware of changes in cognition; fluctuates	Likely to hide or be unaware of cognitive deficits
Activities of daily living (ADLs)	May neglect basic self-care	May be intact or impaired	May be intact early, impaired as disease progresses
Instrumental ADLs	May be intact or impaired	May be intact or impaired	May be intact early, impaired before ADLs as disease progresses

Data from Miller² and Mattoo et al.⁴

opposed to a progressive decline in memory, awareness to surroundings, or behavior. In addition, unlike many other disorders, delirium symptoms may fluctuate throughout the day. Those with dementia or other cognitive diseases are more prone to experiencing delirium.²

By definition, delirium presents clinically as the inability to maintain normal sequential thought.⁵ The pathophysiology of delirium is unclear, but it is thought that there is widespread derangement of cerebral metabolism or cerebral insufficiency that leads to decreased synthesis of cerebral neurotransmitters, especially acetylcholine.⁵ The most common type of delirium, affecting 46% of patients, is mixed, which often presents as a waxing and waning pattern of agitated and combative behavior mixed with drowsy and hypoactive behavior.¹

The core group of symptoms are those noted more frequently, such as attention deficits, sleep-awake cycle disturbance, and motor activity changes.⁴ Delirium may also present as psychosis, mood changes, fluctuating level of consciousness, disorientation, memory impairment, and disturbances in speech and language.⁴ These symptoms vary in frequency and generally are seen as a cluster of symptoms; however, symptoms are variable and not limited to these listed.

MEDICATIONS ASSOCIATED WITH DELIRIUM

Many medications have been linked to the development of delirium, but not all providers understand

which medications should be avoided in people at greatest risk. Studies estimate that 12% to 39% of delirium cases stem from a patient's medications.⁶ Virtually any medication can cause delirium in an at-risk elderly patient. Even previously tolerated medications may pose potential risk when the person is acutely ill or as the person ages.⁷ However, several medications across the drug spectrum have been found more likely to exacerbate delirium, including prescription, over-the-counter, complementary, and illicit drugs.^{3,6,7} A systematic review determined that some medications have a higher propensity for causing delirium than others.⁶ Figure 1 provides a hierarchy of medications.

Prospective studies have established that most patients in the intensive care unit (ICU) experience pain, and when left untreated this can have short- and long-term consequences.⁸ Providers need to be aware that the treatment choice of pain may also have consequences. Many ICU patients receive sedating medications to help with pain or anxiety opposed to using a nonpharmacologic approach. For those patients requiring sedation medication, an interruption in use should be used to assess for need and amount.⁸ Randomized, controlled trials have shown a daily interruption of sedation medications lead to fewer days in the ICU, increasing the survival rate overall.⁸

SCREENING TOOLS

Many different tools can be used to assess for mental status changes related to delirium, including

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