Stabilizing and Managing Patients with Altered Mental Status and Delirium

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KEYWORDS

• Altered mental status • Delirium • Emergency department • Management • Antipsychotics

KEY POINTS

- Altered mental status is a common but nonspecific emergency department (ED) presentation that can signify underlying serious pathology.
- Delirium is a more defined mental status change caused by another medical condition, and carries a high morbidity and mortality if missed.
- The ED physician should maintain a high index of suspicion for delirium, because if missed in the ED, it is more likely to be missed on the wards as well.
- Management of delirium is directed toward treating the underlying course, with adjunctive use of antipsychotics and benzodiazepines for management of agitated delirium in the ED.

INTRODUCTION

Altered mental status (AMS) is a common, yet challenging, clinical presentation that emergency medicine physicians encounter. It is present in about 4% to 10% of ED patients[1] and can be seen in all patient populations, from pediatric to geriatric. It is a nonspecific term used to describe the whole spectrum of brain dysfunctions such as dementia, psychiatric disorder, and delirium. Clinical features of patients who are described as having AMS include: bizarre behavior, confusion, hyperalertness, obtundation, stupor, and frank coma. Of the brain dysfunctions that are largely described as

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AMS, delirium carries the highest morbidity and mortality when missed.[2,3] However, emergency physicians miss delirium in 57% to 83% of the cases, because its clinical presentation can be subtle, there is time pressure, or perhaps because it is not sought.[4] Additionally, if the patient is admitted, more than 90% of delirium that is missed in the ED will also be missed in the hospital setting.[4,5] This article provides a practical approach to the recognition, stabilization, and management of AMS in the ED, with an emphasis on delirium.

RECOGNIZING DELIRIUM

Since delirium carries a high morbidity and mortality if missed, but can be subtle to recognize, several screening tools have been used in different clinical settings to facilitate this diagnosis. Some of the tools include Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) and confusion assessment method (CAM).

Based on the DSM-5 and CAM algorithm, delirium could be defined as an acute change in mental status from baseline with fluctuation in awareness, attention, and cognitive function, caused by a medical condition, substance intoxication, or withdrawal. These changes in cognitive function include perceptual disturbances, memory impairment, disorganized thinking, and disorientation. Delirium can also cause emotional symptoms, including anxiety and behavioral disturbance in addition to the changes in the sleep cycle. The DSM-5 criteria and the CAM algorithm for delirium are described in **Box 1** and **Fig 2**.

Box 1
Confusion assessment method algorithm

Feature 1: Acute Onset and Fluctuating Course

This feature is usually obtained from a family member or nurse and is shown by positive responses to the following questions:

Is there evidence of an acute change in mental status from the patient's baseline?

Did the (abnormal) behavior fluctuate during the day (ie, tend to come and go), or increase and decrease in severity?

Feature 2: Inattention

This feature is shown by a positive response to the following question: Did the patient have difficulty focusing attention (eg, being easily distractible) or having difficulty keeping track of what was being said?

Feature 3: Disorganized Thinking

This feature is shown by a positive response to the following question: Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

Feature 4: Altered Level of Consciousness

This feature is shown by any answer other than "alert" to the following question:

Overall, how would you rate this patient's level of consciousness? (alert [normal], vigilant [hyperalert], lethargic [drowsy, easily aroused], stupor [difficult to arouse], coma [unarousable]).

The diagnosis of delirium by CAM requires the presence of features 1 and 2 and either 3 or 4.

From Inouye S, van Dyck C, Alessi C, et al. Clarifying confusion: the confusion assessment method. Ann Intern Med 1990;113(12):941–8. © 2003 Sharon K. Inouye, MD, MPH.

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