Psychiatric Emergencies in the Elderly

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KEYWORDS

• Geriatric psychiatric emergencies • Elderly • Dementia • Abuse
• Psychiatric emergencies • Depression • Delirium • NPH

KEY POINTS

- Over the last few decades, there has been a constant increase in the number of geriatric patients visiting the emergency department.
- Besides correct diagnosis, it is important the clinician provide elderly patients with appropriate resources for admission or discharge.
- Resources also often extend to the patients' families, but diagnosis and having a broad differential diagnosis to identify a potentially serious underlying psychiatric emergency in the elderly population is the first, vital step.
- Diagnosis and treatment of geriatric patients can be particularly challenging, given the associated medical comorbidities, polypharmacy, and underlying psychosocial issues that do not make for a straightforward diagnosis and management.

INTRODUCTION

"I can see the words hanging in front of me and I can't reach them, and I don't know who I am, and I don't know what I'm going to lose next," says Alice Howland, the main character in the 2015 film *Still Alice* that highlights the reality of progressive Alzheimer disease and its emergent manifestations. In 2012, the number of people older than 65 years was 43.1 million, composing about 13.7% of the total population. By 2050, the population of Americans 65 years and older is expected to be nearly 87 million and will compose nearly 21% of the total population. This number represents a 147% increase in the geriatric age group compared with a mere 49% increase in the population younger than 65 years.[1] Over the last few decades, there has been a constant increase in the number of geriatric patients

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visiting the emergency department (ED). According to the 2011 Centers for Disease Control and Prevention National Hospital Ambulatory Medical Care Survey, almost 15% of total ED visits comprised patients 65 years and older.[2] Diagnosis and treatment of these patients can be particularly challenging given the associated medical comorbidities, polypharmacy, and underlying psychosocial issues that do not make for a straightforward diagnosis and management. This review article identifies common psychiatric emergencies among the geriatric population and its associated management.

DELIRIUM

According to the *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition) (*DSM-IV*) criteria, delirium is an acute disturbance of consciousness with decreased attention, change in cognition, or development of perceptual disturbance that develops over a short period of time with diurnal fluctuations and evidence that the disturbance is caused by a general medical condition, substance abuse or withdrawal, or multiple causes. Although delirium is a common psychiatric emergency that affects an estimated 30% to 50% of hospitalized elderly patients,[3] delirium still poses significant diagnostic challenges with nondetection rates as high as 70%.

The onset of delirium is normally rapid with fluctuations in consciousness. The patient history is very helpful in ascertaining sudden changes in cognition that are perhaps related to underlying medical conditions (ie, urinary tract infection [UTI], recent fall), medication use, and risk of withdrawal from drugs or alcohol. Delirium can be categorized into 3 subtypes: hyperactive, hypoactive, and mixed.[4] Patients with hyperactive delirium present very hypervigilant, restless, or agitated and can complain of auditory or visual hallucinations. The hypoactive form of delirium is associated with increased lethargy, somnolence, and dulled psychomotor function. This form of delirium is often overlooked by clinicians and mistaken for depression.[5] Finally, mixed delirium is associated with features of both hyperactive and hypoactive types.

Tools that can be used in the ED include the Confusion Assessment Method (CAM), which is a short, standardized diagnostic algorithm of delirium and the Memorial Delirium Assessment (MDA) scale, which can be used to quantify the severity of the delirium. CAM includes 2 parts. Part 1 is an assessment instrument that screens for overall cognitive impairment. Part 2 includes only those 4 features that were found to have the greatest ability to distinguish delirium or reversible confusion from other types of cognitive impairment. The tool can be administered in less than 5 minutes. It closely correlates with the *DSM-IV* criteria for delirium. **Boxes 1** and **2** list the CAM instrument and diagnostic algorithm.

The MDA scale is a 10-item, 4-point, clinician-rated scale that is designed to quantify the severity of delirium. **Fig. 1** lists the 10 questions associated with the MDA.

MDA total scores differ significantly between patients with delirium and those with other cognitive impairment disorders or no cognitive impairment. It is also used for making the diagnosis of delirium, and a cutoff score of 13 has been shown to be useful for making the diagnosis of delirium.[6] In a fairly robust study that compared assessment scales for delirium, it was found that the CAM is the most useful instrument in terms of its accuracy, brevity, and ease of use by clinicians and lay interviewers.[7]

Managing delirium implies identifying and managing the underlying cause. Environmental interventions, such as noise reduction, proper illumination, stimulus modification, cueing, and reassurance, are integral parts of delirium treatment.[8] If patients' safety and ability to participate in medical management is compromised, pharmacologic interventions may be required. Most evidence supports the use of low-dose haloperidol, with higher doses being associated with adverse effects.[9]