

Intensive Care and its Discontents

Psychiatric Illness in the Critically Ill

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KEYWORDS

- Intensive care • Critical illness • Delirium • Depression • Anxiety • Sleep problems • Pain

KEY POINTS

- Psychiatric illness, including delirium, substance withdrawal, depression, anxiety, and posttraumatic stress disorder, frequently complicate intensive care unit admissions.
- These illnesses can adversely affect recovery from critical illness and quality of life after discharge.
- Early recognition and management can ameliorate the negative impact of these illnesses both during a critical illness and after.

INTRODUCTION

More than 5 million patients are treated in intensive care units (ICUs) annually in the United States.¹ It is increasingly being recognized that simply preventing mortality should no longer be considered an optimal outcome of an ICU stay. Critically ill patients can develop a host of cognitive and psychiatric complaints during their ICU stay, many of which (sleep problems, anxiety, posttraumatic stress disorder (PTSD), depression, cognitive problems) can persist for weeks or months following discharge from the ICU and can seriously affect the person's quality of life, including the ability to return to work.² These problems have collectively been called post-intensive care syndrome (PICS).³ Given how common these morbidities can be, it is essential that clinicians recognize the onset of some of these syndromes during the patient's ICU stay so that

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appropriate measures may be taken to ameliorate their incidence in the ICU and prevent their occurrence after discharge. This article describes some of the most common psychiatric problems encountered by clinicians in the ICU. It reviews basic principles of assessment and management, including both pharmacologic and nonpharmacologic interventions. As mentioned earlier, research into outcomes of ICU treatment has traditionally focused on physical health, length of hospital stay, and mortalities. As this article makes clear, a more comprehensive approach is needed in order to decrease patient suffering, improve morbidity and mortality, and ensure that critically ill patients can return to the highest quality of life after their ICU stay.

ASSESSMENT AND MANAGEMENT OF DELIRIUM IN THE CRITICALLY ILL

Delirium is characterized by a disturbance of consciousness with accompanying change in cognition. It typically manifests as a constellation of symptoms with an acute onset and a fluctuating course.⁴ Delirium is associated with increased mortality in ICU patients, prolonged ICU and hospital lengths of stay, and cognitive impairment after discharge.⁵ The differential diagnosis for a patient experiencing altered sensorium is broad and this article focuses on delirium in ICU patients only.

Delirium occurs in up to 80% of critically ill patients, especially those who are mechanically ventilated. Its 3 subtypes are:

- Hyperactive
- Hypoactive
- Mixed

Its diagnosis is often missed unless screening tools are used.⁶ One of the most frequently used screening tools for this is the Confusion Assessment Method for use in the ICU (CAM-ICU). It evaluates 4 features: (1) an acute change in mental status, (2) inattention, (3) disorganized thinking, and (4) altered level of consciousness. This test can be completed in 2 to 3 minutes with a sensitivity and specificity greater than 90%.⁷ Other screening tools include Intensive Care Delirium Screening Checklist (ICDSC), Nursing Delirium Screening Scale, Delirium Detection Score, and Cognitive Test for Delirium.⁸ Only CAM-ICU and ICDSC are recommended by Society of Critical Care Medicine (SCCM) guidelines.⁵ A recent meta-analysis found the ICDSC to have 74% sensitivity and 81.9% specificity, whereas CAM-ICU was 80% sensitive and 95.9% specific.⁹

Risk factors for delirium in the ICU include a history of alcohol abuse, previous history of neurocognitive disorder (dementia), severity of illness, endotracheal or tracheostomy tube, no visible daylight, isolation, no visitors,¹⁰ and benzodiazepine (BZD) use.⁵

No pharmacologic intervention is recommended for prevention of delirium.⁵ If medication is needed, dexmedetomidine is recommended instead of benzodiazepines.⁵ An analgesia-first strategy should be used in mechanically ventilated patients⁵ and adequate pain control must be maintained (discussed later). Early deep sedation in the ICU has been associated with delayed time to extubation; increased ICU length of stay; increased mortality; and, in turn, higher prevalence of delirium in these patients.¹¹ Nonpharmacologic techniques that have shown benefit include daily awakening trials, daily spontaneous breathing trials, early mobility and exercise,⁸ music, reorientation and cognitive stimulation,¹² promoting sleep by controlling light and noise, opening and closing blinds at appropriate times, and decreasing stimuli at night.⁵ There are no recommendations regarding mode of mechanical ventilation.⁵

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