

Delirium and Dementia



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KEYWORDS

• Delirium • Dementia • Screening • Management • Emergency department

KEY POINTS

- Delirium is an acute loss of cognition that occurs in 10% to 17% of older emergency department (ED) patients and is associated with death, accelerated functional and cognitive decline, and loss of independence.
- Because delirium is usually precipitated by a medical illness, a comprehensive diagnostic workup is needed to uncover its underlying cause.
- When evaluating a delirious patient with little or no vulnerability factors (eg, dementia), ED providers should be highly concerned for an underlying life-threatening illness.
- Dementia is a gradual loss of cognition that is usually irreversible and is typically not caused by a medical illness.
- ED providers will miss delirium and dementia unless they are screened for with validated assessments.

INTRODUCTION

Approximately 35% to 37% of older emergency department (ED) patients will have cognitive impairment.^{1,2} The 2 most common forms are delirium and dementia. These neurocognitive syndromes can negatively affect the ED provider's ability to provide safe and appropriate clinical care, especially when they are unrecognized by providers. There is also a lack of understanding of what delirium and dementia are because many ED providers frequently use these terms interchangeably. These are 2 distinct syndromes with drastically different prognoses and diagnostic evaluations. At the most basic level of distinction, delirium is an acute loss cognition that is considered reversible and is a marker for adverse patient outcomes. Dementia's cognitive decline is more insidious, is not considered reversible, and does not carry the same prognostic significance as delirium. However, the presence of dementia (like delirium) significantly affects clinical care in the ED. Dementia is among the more powerful

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predisposing factors for delirium. For this reason, delirium prevention strategies are recommended for demented patients without delirium during hospitalization. This article describes the epidemiology of delirium and dementia in the ED and how it affects clinical care and patient outcomes. Screening for both delirium and dementia in the context of the busy ED environment, as well as their diagnostic evaluation and management, is discussed.

DELIRIUM

Definitions and Epidemiology in the Emergency Department

Delirium is characterized by a disturbance in attention and awareness that is accompanied by an acute loss in cognition that cannot be better accounted for by a preexisting or evolving dementia.³ This form of acute brain failure occurs in 7% to 17% of older ED patients.^{4–14} Delirium can develop acutely over a period of hours or days, and the degree of impairment will tend to fluctuate over time. Although inattention is considered the cardinal feature of delirium,^{15,16} patients with delirium often have disorganized thought, perceptual disturbances, disorientation, and sleep–wake disturbances.¹⁵ Delirium in the ED should not be considered a transient event. It can persist into hospitalization in 72% to 77% of cases with a median duration of 3 days, and 46% will remain delirious at hospital discharge.^{14,17}

The negative consequences of delirium are well-established. In older ED patients, delirium is associated with increased in-hospital and long-term mortality,^{10,11,14,18} accelerated functional and cognitive decline,¹⁷ prolonged hospital length of stays,^{18,19} unanticipated intensive care unit admissions,^{14,18} discharge to a skilled nursing facility,¹⁸ and increased 30-day rehospitalizations.¹⁸ Approximately 25% of older ED patients with delirium will be discharged home after their ED stay.^{4,10,19} Notably, these patients are more likely to die compared with their nondelirious counterparts.¹⁰ Finally, a significant proportion of delirious patients are able to recall their experience,²⁰ and this can cause significant distress in 50% to 80% patients.^{20–22}

Delirium is Heterogeneous

Delirium is a heterogeneous syndrome and can vary by psychomotor activity, arousal, and severity. Delirium can be subtyped by these heterogeneity factors and may have prognostic implications. Subtyping delirium by psychomotor activity is generally the most widely studied nomenclature for this condition.²³ Psychomotor activity is based on the patient's motor activity, speech, and level of arousal.²⁴ There are 4 psychomotor subtypes of delirium: hypoactive, hyperactive, mixed,²⁵ and no subtype,^{26–29} and it is hypothesized that each psychomotor subtype has different underlying pathophysiological mechanisms and etiologic factors.^{25,30,31} Hypoactive delirium is described as quiet delirium and patients with this subtype appear drowsy, somnolent, or lethargic. Because its clinical presentation can be very subtle, hypoactive delirium is frequently undetected by health care providers³² and may be ascribed to other causes such as depression or fatigue.^{33,34} Patients with hyperactive delirium have increased psychomotor activity; these patients may appear restless, anxious, agitated, or combative. Hyperactive delirium is more easily recognized by health care providers, yet it is the least common subtype in older ED patients.⁶ Mixed-type delirium exhibits fluctuating levels of psychomotor activity; the patient can exhibit hypoactive symptoms at 1 moment and hyperactive symptoms several hours or even seconds later. Hypoactive (decreased psychomotor activity) delirium is considered to portend the worst prognosis and is associated with higher short-term and long-term mortality.^{29,35–37}

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