

Delirium

Delirium - F05 (Clinical term: Other mental disorders due to brain damage and dysfunction caused by physical disease Eu05)

Presenting complaints

- Families may request help because patient is suddenly more confused or becomes either much quieter or agitated and disturbed.
- Patients may appear uncooperative, fearful or tearful.
- Delirium occurs in many older patients hospitalized for physical conditions.

Diagnostic features

Acute onset, usually over hours or days, of:

- confusion (patient appears disoriented for time and place, may misidentify people and have a poor grasp of situations and surroundings)
- impairment of memory
- disturbance of conscious level with reduced ability to focus or shift attention and markedly diminished attention span.

May be accompanied by:

- agitation (hyperactive delirium) or, more commonly, apathy (hypoactive delirium)
- changes in mood, eg fearfulness, sadness
- perplexity and sometimes apathy
- illusions (misperceptions of normal stimuli)
- suspiciousness
- disturbed sleep (reversal of sleep pattern)
- disturbed thinking, often reflected in incoherent speech
- hallucinations (can occur in any sensory modality but visual hallucinations are most common)
- autonomic features (eg sweating, tachycardia, tachypnoea).

Symptoms often develop rapidly and may change from hour to hour. They are characteristically worse at night.

Delirium may occur in patients with previously normal mental function but is more common in those with previous degenerative brain disorder. Delirium may occur in patients with previously normal mental function or in those with dementia. People with chronic physical illnesses are also more vulnerable to delirium, and in these groups it might be precipitated by apparently innocuous things, including minor infections, changes to any drug treatment and changes in environment.

Differential diagnosis

Acute psychotic disorders - F23 (if symptoms persist, delusions and disordered thinking predominate, and no physical cause is identified).

Delirium in the setting of dementia could be missed if the pre-existing dementia is not recognized. Some features of quiet delirium occur in acute dysphasias (stroke) and depression, and of hyperactive delirium in acute psychotic episodes (see below) or mania.

Essential information for family

- Strange behaviour or speech and sudden confusion can be symptoms of a medical illness, especially if the patient is elderly or has dementia.
- Seek help urgently if patient becomes confused.

General management and advice to family

(ref 64)

- Delirium is a medical emergency with appreciable mortality.
- Hospitalization might be required because of agitation or the physical illness that is causing delirium. Patients may need to be admitted to a medical ward in order to diagnose and treat the underlying disorder. In an emergency, where there is risk to life and safety, a medically ill patient may be taken to a general hospital for treatment under common law, without using the Mental Health Act. In such a case, a medical doctor may make this decision without involvement of a psychiatrist.
- Take measures to prevent the patient from harming themselves or others (eg remove unsafe objects, restrain if necessary).
- Supportive contact with familiar people can reduce confusion.
- Provide frequent reminders of time and place and minimize distracting stimuli to reduce confusion.
- Keep lighting levels bright to minimize visual illusions.
- Keep up fluid and food intake as much as possible (ref 65)
- Try and encourage mobility (ref 65)
- Try and encourage a restful sleep at night.

References

64 Rabins PV. Psychosocial and management aspects of delirium. *Int Psychoger* 1991, 3(2): 319-324. (BV) This is a review of 21 papers, concluding that the evidence base is very thin.

65a Inouye SK, Bogardus ST Jr, Charpentier PA et al. A multicomponent intervention to prevent delirium in hospitalized older patients. *N Engl J Med* 1999, 340: 669-676. (CIII) Intervention was associated with significant improvement in the degree of cognitive impairment among patients with cognitive impairment at admission, and with a reduction in the rate of use of sleep medication among all patients.

65b A Cochrane Review will soon be available. Britton A, Russell R. Multidisciplinary team interventions for delirium in patients with chronic cognitive impairment (Cochrane Review). In: *The Cochrane Library*, Issue 2, 2003. Oxford: Update Software Issue 4, 2003.

Medication

(ref 66)

- Avoid use of sedative or hypnotic medications (eg benzodiazepines) except for the treatment of alcohol or sedative withdrawal.
- Antipsychotic medication in low doses (BNF section 4.2.1) might sometimes be needed to control agitation, psychotic symptoms or aggression. Beware of drug side-effects (drugs with anticholinergic action and antiparkinsonian medication can exacerbate or cause delirium) and drug interactions.
- When drugs are required because of severe behavioural disturbance or risk to self and/or others, low-dose risperidone is the usual drug of first choice, except in alcohol or drug withdrawal states or in patients with liver disease in might be helpful.
- If Lewy body dementia is suspected, benzodiazepines are preferred to antipsychotics. because the latter can be fatal (see [Dementia - F03#](#)) (ref 67).

References

66 Rummans TA, Evans JM, Krahn LE, Fleming KC. Delirium in elderly patients: evaluation and management. *Mayo Clinic Proc* 1995, 70(10): 989-998. (BV). This reviews 55 papers, concluding that the evidence base is thin.

67 Ballard C, Grace J, McKeith I et al. Neuroleptic sensitivity in dementia with Lewy bodies and Alzheimer's disease. *Lancet* 1998, 351: 1032-1033. (CV) This is a case-register study. Other interventions should be explored before the use of neuroleptics in patients with dementia, particularly in those with dementia with Lewy bodies.

Referral

Referral to secondary mental health services is rarely indicated. Referral to a physician is nearly always indicated if:

- the cause is unclear
- the cause is clear and treatable but carers are unable to support the patient or they are living alone
- drug or alcohol withdrawal or overdose or another underlying condition necessitating inpatient medical care is suspected.