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FIVE THINGS TO KNOW ABOUT ...

Delirium

Choosing Wisely Canada
In partnership with the Canadian Medical Association

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1 Delirium is often missed

Although delirium is common (prevalence 18%–50% in hospital, up to 88% in palliative care),[1,2] the diagnosis, particularly hypoactive delirium, is often missed owing to symptom fluctuation and transient lucidity, as well as clinical features that overlap those of dementia and depression.[3] The diagnosis is clinical, but nursing observational and cognitive screening tools or brief tests of attention may improve detection. A collateral history of an acute change in mental status should prompt use of the Confusion Assessment Method.[4,5]

2 Delirium is usually multifactorial

Delirium arises from the interplay of predisposing (e.g., advanced age, dementia) and acute precipitating factors.[1] Superimposed precipitants include infection, medications (e.g., psychoactive and anticholinergic drugs), drug withdrawal, metabolic abnormalities and other medical conditions. Delirium's reversal hinges on the identification of treatable precipitants.

3 About one-third of all delirium episodes in older adults in hospital can be prevented

Multicomponent nonpharmacological interventions are effective for preventing and treating delirium in many patients.[1] The Hospital Elder Life Program targets risk factors[6] with a focus on orienting activities, hydration, sleep, mobility and avoidance of sensory deprivation. Unnecessary use of catheters should be avoided.[7] Other strategies include comprehensive geriatric assessment perioperatively, use of designated delirium rooms and comprehensive medication review.

4 Benzodiazepines should be avoided as first-line agents in the pharmacologic management of delirium

Benzodiazepines can exacerbate delirium; first-line use is limited to the management of alcohol or sedative-hypnotic withdrawal (Box 1). Limited evidence suggests short-term use of antipsychotic agents (e.g., haloperidol, olanzapine) in the lowest clinically effective doses for the management of severe hyperactive (agitated) delirium.[7] Antipsychotic agents should be used cautiously in Parkinson disease or Lewy body dementia, because of the risk of extrapyramidal adverse effects.

Box 1: Choosing Wisely recommendation

Do not use benzodiazepines or other sedative–hypnotic agents as first-line treatment in older adults with insomnia, agitation or delirium.

- Large-scale studies consistently show that the risk of motor vehicle collisions, falls and hip fractures leading to hospital admission and death can more than double in older adults taking benzodiazepines and other sedative–hypnotic agents. The number needed to treat with a sedative–hypnotic for improved sleep is 13, whereas the number needed to harm is only 6. Older patients, their caregivers and their health care providers should recognize these potential harms when considering treatment strategies for insomnia, agitation or delirium.

Source: Canadian Geriatrics Society, Choosing Wisely (www.choosingwiselycanada.org/recommendations/canadian-geriatrics-society-2/)

5 Delirium has a poor prognosis

Delirium is associated with increased mortality and morbidity; cognitive and functional decline are common, as is placement in long-term care.[1,8] Symptoms usually persist, and recovery rates are poor in older patients. Delirium may worsen pre-existing and increase the risk of new-onset dementia.[1] Patients may feel threatened and anxious.[3] Family members should be provided with education and support.

CMAJ is collaborating with Choosing Wisely Canada (www.choosingwiselycanada.org), with support from Health Canada, to publish a series of articles describing how to apply the Choosing Wisely Canada recommendations in clinical practice.

See references, Appendix 1, www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.141248/-/DC1

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