Delirium in patients with advanced or chronic disease

"Comfort packs" for the dying

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Delirium

Acute confusional state resulting from diffuse organic brain dysfunction

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Why is it important ?...COMMON

1/3 of patients over 70 admitted to hospital

1/3 of elders presenting to ER

SNU

- 16% delirious on admission
- Up to 60 % of all LTC patients have delirium during SNU stay

25-50 % advanced cancer patients

85% of patients in last several weeks of life

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Why is it important?-We MISS it (often)

- 22-66 % of cases of delirium are not diagnosed or treated
- Factors associated with nonrecognition
  - Hypoactive delirium
  - Pre-existing cognitive impairment
  - Advanced age

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Why is it important ? MORBID

- In hospital, TENfold increase risk of death
- One year mortality after delirium 35-40%
- Suffering for patient….and for family
- MOST patients recall their delirium, MOST (80%) said it was distressing for them (hypoactive =hyperactive)
- Hallucinations most associated with distress
- Sense of threat, imprisonment/restraint/trapped
- Shame , embarrassment with recall

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Who is most likely to get this ?

- Advanced age
- “Vulnerable brain”
- Functional, visual, hearing impairments
- Dehydration/malnutrition
- Advanced chronic or terminal illness
- Multiple medications

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What do we do about this ?

- Prevent it
- Diagnose it
- NAME it (not ‘anxious’, ‘restless’, ‘a little confused’, ‘agitated’, ‘nervous’, etc.)
- Treat it

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Diagnose it ....and NAME it

- Acute onset, fluctuating course AND
- Difficulty maintaining attention AND
- Disorganized thinking OR
  Altered consciousness (more or less alert)
- Hyperactive/hypoactive/mixed
- NAMING it for patient, family, chart (‘delirium’/ ‘encephalopathy’)
- NOT dementia, psychosis, chronic mental illness, depression

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Look for reasons why !

DME / Top to bottom

- Drugs
- Metabolic (systemic)
- Environmental
- Top to bottom exam/consideration of precipitating conditions

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DRUGS

Drugs we GIVE that cause/contribute

- Opioids
- Benzodiazepines
- Anticholinergic meds
- Steroids
- Antibiotics(fluoroquinolones)
- H2Blockers
- Others (digoxin, theophylline…)

Drugs we DIDN't give that contribute

- Analgesics (uncontrolled pain)
- Withdrawal syndromes
  Opioid
  Benzodiazepines
  ETOH
  SSRI

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Metabolic/systemic

Metabolic

Hyper/hyponatremia

Hypercalcemia

Hypoxia/hypercarbia

Uremia

Hepatic encephalopathy

Hypoglycemia

Systemic

- Infection/ sepsis
- Fever
- Dehydration
- Anemia

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Environmental

- Sleep disruption
- Noisy/chaotic environment
- Unfamiliar/ changing caregivers
- Hearing/visual impairment
- Immobility

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BODY-top to bottom consideration

- Head- tumor, bleed, CVA-UNCOMMON in absence of localizing signs
- Thorax- Pneumonia, PE, MI, other
- Abdomen/pelvis- -
  distension of hollow viscus as cause for delirium
  Stomach, small intestine, large bowel
  Bladder-urine retention -
  inflammatory or other source

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Terminally ill

- "Terminal delirium/agitation".... 'the hard road'.
  Probably 10-15% of dying people, agitation, sometimes pronounced. Treat as needed for patient/caregiver safety
- "Near death awareness"
  Dying person seeing loved ones who have died
  Invitation to go with, through door, down the path, on the bus…
  Often comforting /pleasant for the dying patient
  Generally in the last days to a week prior to death

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Treatment of delirium

- Non-pharmacologic is MOST important-
  Identify and correct contributing cause(s)
  Medication, pain, distended bladder, hydration, infection
  Environmental contributor-mobility, reorientation measures, hearing/vision aides, other
- Explanation of delirium to patient and especially to family
  MEDICAL condition, NOT psychiatric illness, NOT dementia, related to underlying illness, NOT reflection of patient's true nature or emotions

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Treatment of delirium

- Antipsychotics-NOT the panacea we have previously believed
- SOME benefit for patients with pronounced, agitated delirium that is harmful for patient or others… 'treatment of symptoms of delirium'
- Conventional (Haldol) and atypical (olanzapine, risperidone, quetiapine)- use for delirium is off label
- FDA warning for both classes in elderly patients with dementia (higher risk of death), risk of QT prolongation, risk with Parkinsons /Lewy body dementia patients of worsening symptoms permanently

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Pharmacologic treatment delirium-antipsychotics

- Haloperidol- Less sedating, more EPS (increased if daily dose >3 mg) PO, SL, SQ….initial dose 0.25- 0.5 mg, up to 3 mg daily
- Risperidone- slightly less EPS than haloperidol PO, SL, IM….initial dose 0.25-0.5 mg, up to 3 mg daily
- Olanzapine- more sedating, PO, SL, IM ….initial dose 2/5-5mg, up to 20 mg/D
- Quetiapine-more sedating, PO….initial dose 12.5-25 mg ,up to 50 mg/D

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Pharmacologic treatment delirium-benzodiazepine

- Associated with decreased cognition/more confusion
- Important in management of withdrawal delirium
- Use if sedation is needed
- Lorazepam may have paradoxical agitation (NOT class effect, if develops, can use different benzodiazepine)
- Lorazepam-PO, SL, SQ, IV, 0.25-0.5 mg to start, up to 2 mg daily unless sedation is required, then increase to effect

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Emergency "comfort pack" for terminally ill patients

- Rationale…. "Why should we consider this ?"
- What symptoms do we expect in the dying days of patient in our care? How promptly can we manage this at 2 am on a Sunday morning?
- Pain, dyspnea, delirium, nausea/vomiting, anxiety, secretions
- Cost, safety, accessibility, regulatory issues in creating kit
- What is possible is specific to environment/facility

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Medication options

– Pain/dyspnea-opioid

– Oral morphine solution 20 mg/ml, po/SL, titrate from low dose, low volume….BUT harder for narc counts, dilution/diversion, 15 ml smallest volume (300 mg morphine)

– Oral oxycodone IR tablets 5 mg (equals 7.5 mg morphine) crush SL/po q 2-4 hours prn

– Oral hydromorphone tablets 2 mg (equals 8 mg morphine) crush SL/po q 2-4 hours prn

– Delirium/agitation/anxiety

– Haloperidol –solution (2 mg/ml), 0.5 mg tablets crush SL/po.
Regulatory issues-For agitated delirium in terminally ill patient, permitted .
AMDA Physician Information Tool Kit "Palliative Care in LTC Setting"
notes "Most authorities recommend haloperidol as the first-line medication for delirium".

Risperidol 0.25 and 0.5 mg tablets, RisperDAL M-tab (oral dissolving tab) much more expensive

Olanzapine 2.5 and 5 mg tablets, Zydis oral dissolving tab much more expensive

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Medication options

- Nausea/vomiting

  IF haloperidol is in kit, effective antinausea med
  Ondansetron 4 mg, ODT more expensive
  Alternatives-Compazine po/PR, other

- Secretions

  Hyoscyamine SL (LEVSIN SL) 0.125 mg SL q 4 hr
  Atropine/ scopolamine patch – CNS penetration, delirium
  Can use for smooth muscle spasm (bowel/ bladder spasm)

- Acetaminophen

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