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FAST FACTS AND CONCEPTS #1 (PDF)

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Background: Some degree of loss of cognitive function occurs in most patients in the week or two before death. The typical scenario presented to housestaff is a late-night call from a ward nurse saying, "Mr. Jones is confused, what should we do". This Fast Fact reviews assessment and management issues in terminal delirium.

Key teaching points:

1. The term "confusion" is not an accurate descriptive term—it can mean anything from delirium, dementia, psychosis, obtundation, etc. Patients need a focused assessment, including a brief mini-mental examination. Clinicians should use one of several validated delirium assessment tools to help quantify and document cognitive function.
2. Delirium can be either a hyperactive /agitated delirium or a hypoactive delirium. The hallmark of delirium is an acute change in the level of arousal; supporting features include altered sleep/wake cycle, mumbling speech, disturbance of memory and attention, and perceptual disturbances with delusions and hallucinations.
3. The most common identifiable cause of delirium in the hospital setting is drugs: anti-cholinergics (e.g. anti-secretion drugs, anti-emetics, anti-histamines, tricyclic anti-depressants, etc.), sedative-hypnotics (e.g. benzodiazepines), and opioids. Other common causes include metabolic derangements (elevated sodium or calcium, low glucose or oxygen); infections; CNS pathology; or drug/alcohol withdrawal.
4. The degree of work-up to seek the cause of delirium is determined by understanding the disease trajectory and overall goals of care (see Fast Fact #65).
5. The drug of choice for most patients is a major tranquilizer. There is one controlled clinical trial of haloperidol versus lorazepam in HIV patients; haloperidol was the superior agent. Haloperidol is administered in a dose escalation process similar to treating pain. Start haloperidol 0.5-2 mg PO or IV q1hour PRN. Benzodiazepines can be used, but may cause paradoxical worsening of symptoms.
6. Non-pharmacological treatments should always be used in delirium management: reduce or increase the sensory stimulation in the environment as needed; ask relatives/friends to stay by the patient; frequent reminders of time/place.

See Fast Fact #60 for a discussion of newer pharmacological treatments

References

1. Yennaurjalingam S et al. Pain and terminal delirium research in the elderly. Clin Geriatr Med. 2005;21(1):93-119.
2. Lawlor PG, et al. Occurrence, causes and outcome of delirium in patients with advanced cancer. Arch Int Med. 2000;160:786-794.
3. Brietbart W, Marotta R, Platt M, et al. A double blind trial of Haloperidol, Chlorpromazine and Lorazepam in the treatment of delirium. Am J Psych. 1996; 153:231-237.
4. Breitbart W, Alici Y. Agitation and delirium at the end of life. "We couldn't manage him." JAMA 2008; 300(24):2898-2910.

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