

Management of Delirium in the Elderly Patient on the AMU

Delirium is characterised as a disturbance of consciousness cognitive function or perception which has an acute onset and fluctuating course.

It can be subdivided in to hypoactive, hyperactive and mixed depended on the presentation.

Symptoms can vary from withdrawn, quiet and sleepy to aggressive, hyperactive and restless.

Causes of Delirium

- Infection
- Renal failure
- Liver failure
- Heart failure
- Hypoglycaemia
- Dehydration
- Constipation
- Medication and polypharmacy
- Acute drug withdrawal
- Intra-cranial pathology
- Vitamin deficiency e.g. B12/folate
- Hormone imbalances e.g. TFTs

Risk factors for the development of Delirium

- Age > 65
- Unfamiliar environment
- Pre-existing dementia or psychiatric illness
- Sensory disturbance
- Pain
- Hypoxia
- Severe physical co-morbidities
- Hip fractures
- Nicotine withdrawal

Treatment of Delirium

•CORRECT THE UNDERLYING CAUSE

- Supportive nursing
- De-escalation techniques
- Short course of anti-psychotics , review daily

1st line

ORAL Haloperidol 500 micrograms 8 hourly

2nd line - Severely aggressive patients

IM Haloperidol 500 micrograms,
titrate dose in increments of 500 micrograms
hourly to a maximum of 2mg.

- **Avoid the use of anti-psychotics in patients with Parkinsons/Lewy body dementia – consider Quetiapine 25mg OD or Lorazepam 0.5mg orally however...**
- **Try to avoid the use of Benzodiazepines unless alcohol withdrawal where possible**
- **Only use IM medication in severely agitated patients refusing oral medication.**

Investigation of Delirium

- Baseline observations
- Detailed Examination
- Bloods : FBC, U+E, LFT, Ca, TFTs, B12, folate, Glucose
- ECG
- CXR
- Urinalysis
- Functional assessment
- Collateral history relatives/carers
- MMSE if Delirium suspected
- CT brain/Lumbar puncture **if clinically indicated**