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10 delirium myths debunked

A consultation-liaison psychiatrist is called in to help manage "schizophrenia" in a middle-aged attorney who is recovering from a complicated cardiac bypass procedure. This patient is not mentally ill, the psychiatrist realizes, but has delirium with rapid-onset neuropsychiatric symptoms noted by fluctuations in arousal and associated changes in sleep, mood, personality, and cognition. This example illustrates 1 of 10 myths about delirium:

1 My patient is paranoid, therefore he or she must be schizophrenic

Patients with delirium may present with perceptual disturbances such as hallucinations, delusions, or paranoia. An otherwise highly functioning individual with symptom onset while in a medical setting likely has delirium, not a chronic mental disorder such as schizophrenia.

2 Delirium is rare

Delirium is found frequently in medically ill populations. In some groups, such as stem-cell transplant patients, rates may approach 50%. Risk factors include medical severity and advanced patient age.[1]

3 Delirium is not serious

Delirium is associated with increased morbidity and mortality. It is a marker for "cerebral insufficiency"—reversible impairment in brain function—and requires prompt treatment.[2-4]

4 Sleep deprivation causes delirium

Disrupted sleep in hospitalized patients—otherwise known as "ICU psychosis"—is more likely the result of delirium than the cause. Patients' delirium and sleep both improve when they move from the ICU to a general medical floor, a reflection of their improved medical condition.[5]

5 Delirium goes away rapidly

Delirium usually lasts for days or weeks. Many patients—although superficially improved—still have subtle cognitive deficits and difficulty with daily activities.

6 The patient's medical problem has been treated, so the delirium should resolve

A patient's CNS often needs time to recover, and delirium may persist after the underlying medical cause has been treated. Delirium can be caused by factors other than medical illness, such as sedating, analgesic, or antiemetic medications.

7 My delirious patient cannot make medical decisions

Many patients with delirium can make decisions during more lucid periods. As their delirium improves, they should be able to participate in decision-making.

8 My patient cannot be delirious because he or she is oriented to time and place

Simple orientation questions can miss subtle signs of delirium. Watch for an inability to function cogni-

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tively at the individual's baseline level. For example, a software engineer who is unable to draw a clock could be delirious.

9 My patient has depression, not delirium, because he or she is not getting out of bed

Delirium can present with changes of mood, energy, and personality that mimic depression. Even severely depressed individuals can function at a basic cognitive level and maintain daytime wakefulness, whereas patients with delirium may not.

10 Delirium cannot be treated

Manage delirium by evaluating and treating underlying medical precipitants such as metabolic derangement, infection, dehydration, hypoxia, pain, or medication effects. Also consider CNS injuries including stroke, head injury, or neoplasm. Research suggests antipsychotic medications at low dosages[6,7] can safely treat delirium. Improving orientation and comfort by reassuring the patient, assessing for anxiety, and reducing excessive noise and stimulation also help.

References

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