

Perspectives on delirium in the elderly

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OPINION

Delirium is a neurobehavioral syndrome related to some systemic disorder. It is characterized by an acute onset, fluctuating course and changes in orientation, memory, attention and behavior. In the elderly, its incidence reaches 50% of hospitalizations, being associated to an increase in length of hospital stay, admission rates in long-stay institutions, functional disorders and mortality, which substantially increases health and social care costs (1,2).

The diagnosis of delirium is eminently clinical and the knowledge of previous baseline mental status of the patient is crucial for it.

There are two clinical presentations of the syndrome: hyperactive and hypoactive forms (patients can oscillate between them). The hypoactive form is more common in the elderly and leads to higher rates of complications and mortality. Although its relevance, about 84 to 95% of delirium cases are not diagnosed by attending physicians (3). The most common instrument used for diagnosis is the Confusion Assessment Method (CAM) and its variations (4). Delirium detection, prevention and management have been used as indicators of quality care of hospitalized older patients (5).

Several studies have shown the importance of its prevention through the early detection of risk factors such as previous cognitive deficit (major risk factor), history of alcohol abuse, age greater than 70 years, polypharmacy, severity of the underlying disease, infections, fractures and physical restrictions (4-6). The treatment of the basic medical condition is of fundamental importance for the resolution of the syndrome.

There is no definitive treatment for delirium and lack of evidence from randomized controlled trials on this field specially considering trials that exclusively includes patients over 60 years.

There is evidence that non-pharmacological treatments based on screening, geriatric consultation, staff education, changes in the environment, pharmacological protocols, presence of family or volunteer, nursing protocols for risk factors and behaviour management, are effective in reducing the incidence of delirium (2,7,8). but once it is established the evidence base remains limited (2,3,7). Lundström et al obtained a reduction in the duration of delirium, length of hospital stay and mortality with an educational program and reorganization of the health service (9), but these results were not replicated in other studies (2,3,7,10,11). Two recent systemic reviews found that non-pharmacological treatment for established delirium had no benefit on duration, severity and mortality but showed an improvement in patient's functional status (12,13).

Most of the non-pharmacological trials uses a group of interventions simultaneously and a multiprofessional approach, so it is not possible to evaluate if one of them is more effective than another. It is the set of them that lead to the results.

There is no consistent evidence that the pharmacological treatment reduces the incidence of delirium and it is not recommended for the prevention of the syndrome (13).

The use of pharmacologic treatment for established delirium is accepted for agitated patients that can cause harm for itself or others, but it is controversial in other settings. The antipsychotics are the drugs of choice. A systematic review compared typical antipsychotics (haloperidol) with atypical antipsychotics (amisulpride, quetiapine, olanzapine and risperidone) for the

treatment of delirium and found that there was no difference of effectiveness between them (14).

Only few trials tested drugs other than antipsychotics for the treatment of established delirium (melatonin, ramaltheon and cholinesterase inhibitors) with no benefits on duration and mortality, but the samples were small, and evidence of larger studies are necessary (15,16). Benzodiazepines should not be used in delirious patients, exception for cases of alcohol withdrawn and abstinence of benzodiazepines, after physician judicious evaluation.

Delirium still a challenge for all the medical and health staff. The efforts should lay on educational programs, prevention and early detection. Patient's family has an important role on the perception of a change on patient's mental base state and contribute to its recovery, so it should not be left aside of the medical decisions. New scientific evidence from randomized controlled trials specially with a population >60 years are needed for further protocols and management of established delirium.

CONFLICT OF INTEREST

None.

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