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Acute delirium

EDITORIAL

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Systematic identification of patients with acute delirium in emergency departments in Norwegian hospitals may benefit multimorbid elderly patients.

For many doctors, the terms 'acute confusion' and 'delirium' conjure up images of agitated and unruly elderly patients. Many of these patients have suffered from hyperactive delirium, a condition that generates concern and an expectation by those around them that 'something must be done'. Both hyperactive delirium and the far more common condition of hypoactive delirium are characterised by a disturbance in attention, often accompanied by additional cognitive symptoms such as visuospatial disturbances, memory impairment or impaired language function (1). Many patients also suffer from hallucinations and delusions (1). While patients with hyperactive delirium virtually always attract attention, those with the hypoactive form tend to lie still in their beds. Patients may frequently fluctuate between hyperactive and hypoactive delirium (2).

As elucidated by the authors of the article *Delirium and cognitive impairment among elderly patients in Norwegian emergency departments*, acute delirium is very common (3). The condition frequently goes undiagnosed, and the authors argue that the hospitals ought to introduce a method to systematically detect acute delirium. Why is this so important?

Acute delirium can be fatal. According to the DSM-5 criteria adopted in 2013, the diagnosis presumes that there is an identifiable causal trigger (1). Infection in the airways or urinary tract is one of the most common causes in elderly patients, but electrolyte disturbances, metabolic defects and not least drugs are other common triggers. This is especially the case for drugs with psychotropic effects, usually in the context of initiation, reduction or withdrawal (4). Elderly patients frequently have no

organ-specific symptoms, even though their organs may be severely affected (5), and this may clinically manifest itself in the form of general symptoms such as fatigue and dizziness or delirium. In order to interrupt an acute delirium, the treatment must target the triggering factor as early as possible. Such treatment may be life-saving. If the acute delirium persists for days or weeks, there is an increasing risk of serious loss of function or death (4).

Several different screening instruments may be of help in diagnosing acute delirium. Traditionally, the Confusion Assessment Measure (CAM) has been widely used in Norway (6). Evensen and co-authors believe that we should rather use the 4AT tool, which is also found in a Norwegian version and appears to have better properties (7). The most important effect of introducing systematic screening of elderly people for delirium in emergency departments, however, is to make nurses and doctors more aware of the condition – irrespective of the instrument used.

In cases of hyperactive delirium, doctors are frequently met with requests from next of kin or care providers to 'allay' the situation with the aid of drugs. However, there is very limited documentation of the effect of such treatment, which may also have adverse effects and exacerbate the delirium (8). Non-pharmacological interventions, such as shielding the patient in a private room, having as few carers as possible and daylight orientation, i.e. that the patient's room is kept light during the day and dark at night, should always be attempted first (3). The next of kin represent an important source of security for many patients with delirium and may constitute a resource in the treatment process.

It is crucial to distinguish between delirium and dementia. A diagnosis of dementia should not be made during an ongoing acute delirium, unless clear information in the medical history indicates that the condition has developed gradually over a long period of time, supported by findings of biomarkers for dementia, such as CT or MRI scans of the brain or findings in the cerebrospinal fluid. The purpose of identifying the cognitive function in patients during emergency hospitalisation is therefore not primarily to diagnose dementia-type illness, but to immediately clarify the patient's level of cognitive function with a view to planning further follow-up.

Introducing systematic identification of patients with acute delirium in the emergency departments of Norwegian hospitals could improve the situation for multimorbid elderly patients – but only if the screening is combined with better knowledge about the diagnostics and treatment of the condition.

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