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Delirium: Confusional States

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Delirium: Confusional States

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INTRODUCTION

Delirium is a disorder commonly seen on the consultation psychiatry service. Often the request for consultation concerns the "acute onset of hallucinations and confusion in an elderly patient." Family members of a patient with delirium are often frightened by observing hallucinations and confusion in a loved one who has no previous mental health history. Medical practitioners, noting psychiatric symptomatology, often mistakenly think the etiology also is psychiatric. This is not the case; delirium is a syndrome of psychiatric symptoms in response to compromised central nervous system (CNS) function.

PREVALENCE

Delirium is a common disorder[1–6] (**Table 1**), occurring in approximately 10% of hospitalized patients.[7] It occurs more frequently in certain at-risk populations, including 30% of post–coronary artery bypass graft (CABG) patients[8] and 50% of post–hip replacement surgery patients.[9] Bodily insults, such as extensive surgery, can contribute to delirium, but there are other predisposing factors as well such as advanced age and pre-existing organic brain disease[7,10,11] (**Table 2**).

Delirium is associated with increased mortality and morbidity. Elderly patients with delirium have a 22% chance of death during their current hospitalization.[12,13] The chance of death in the 6 months following a delirium episode is 25%.[14] Morbidity associated with delirium includes development of dementia,[15] longer hospital stays, poorer recovery from illness, more post-surgery complications, greater use of economic resources, and an increased risk for extended care facility placement.

CLINICAL FEATURES

The hallmark of delirium is the sudden onset (usually over hours to days) of a disturbance of consciousness, attention, cognition, and perception with a fluctuating course that can not be better explained as a dementia. Associated symptoms are disturbances in sleep, psychomotor activity, and emotional regulation. The diagnostic criteria for delirium are listed in **Table 3**.[16]

PRODROME

Prodromal symptoms of delirium usually develop 1 to 3 days prior to the onset of delirium,[16] but often are only recognized retrospective to the development of delirium. They include restlessness, anxiety, irritability, distractibility, and sleep disruption.[7] Although nonspecific, sleep disruption progressing fully to daytime sedation and nighttime wakefulness are indications to assess for early delirium.

TEMPORAL COURSE

Delirium is characterized diagnostically by the abrupt onset of impaired consciousness, cognition, and perceptual problems. Also characteristic of delirium is the fluctuation of symptoms over a 24-hour period. There may appear to be lucid periods, but careful cognitive examination during these periods still shows impaired cognition.[7] Delirium may be divided into the subtypes of hyperactive, hypoactive,[2,11] and mixed delirium[17] based on the characteristics of symptoms during the periods of fluctuation (**Table 4**). Usually delirium lasts 10 to 12 days, but in up to 15% of patients it may last longer than 30 days.[1,18] Resolution of symptoms depends on treatment of and recovery from the underlying medical cause of the delirium. Full recovery from delirium is less likely in patients with Parkinson's disease,[19,20] those with a pre-existing dementia,[1] and in AIDS dementia complex patients,[21] all disorders associated with central nervous system dysfunction.

Hallucinations, agitation, and disorientation have been more associated with hyperactive delirium,[17] while in the hypoactive form confusion and sedation are more commonly seen. Cognitive impairment is seen in all types of delirium.

DIAGNOSTIC FEATURES

Disturbance of Consciousness/Attention

The key symptom that differentiates delirium from dementia is the disturbance of consciousness. Demented

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