SOCIETÀ ITALIANA DI GERONTOLOGIA E GERIATRIA

SIMPOSIO INTERSOCIETARIO FADOI- SIGG
LA COMPLESSITÀ DEL MALATO ANZIANO RICOVERATO IN OSPEDALE
Firenze 30 novembre 2007

FADOI

Delirium: aspetti eziopatogenetici, terapeutici e gestionali

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BMJ

Delirium in older people

John Young,[1] Sharon K Inouye[2]

BMJ 2007;334:842-6

21 APRIL 2007 | VOLUME 334

- Few ill health situations are more degrading to people of any age than loss of reasoning, faculties, and personhood. These are the unpleasant consequences of delirium…
- It is characterised by recent onset of fluctuating inattention and confusion, linked to one or more triggering factors.
- Delirium is a major burden to healthcare services and has been largely ignored by health service planners and practitioners.
- Moreover, healthcare systems and services often unintentionally stimulate or substantially aggravate the development of delirium in older people.
- This might be understandable if delirium was unavoidable or untreatable, but the existing evidence base for delirium is sufficiently robust for prevention or attenuation of the condition to be a realistic proposition.
- There is a pressing need to take this action…

SINONIMI DI DELIRIUM

- Stato confusionale acuto
- Sindrome organica cerebrale
- Encefalopatia tossica
- Encefalopatia metabolica
- Psicosi tossica
- Psicosi esogena
- Sundowning

DSM-IV requires the following essential criteria for a diagnosis of delirium

- **Disturbance of consciousness** (i.e. reduced clarity of awareness of the environment) with reduced ability to focus, sustain, or shift attention.
- **Change in cognition** (e.g. memory deficit, disorientation, language disturbance and perceptual disturbance) that is not better accounted for by a preexisting, established, or evolving dementia.
- **Development over a short period of time** (usually hours to days) and disturbance **tends to fluctuate** during the course of the day.
- There is **evidence** from the history, physical examination, or laboratory findings that the **disturbance is caused by the direct physiological consequences of a general medical condition.**

La diagnosi di **DELIRIUM** è clinica

VARIABILI CLINICHE

Il delirium rappresenta una sindrome eterogenea dal punto di vista sintomatologico

- **DELIRIUM IPERCINETICO** (25%): allucinazioni, deliri, agitazione psicomotoria, disorientamento TS
- **DELIRIUM IPOCINETICO** (25%): confusione, sedazione, sopore
- **DELIRIUM MISTO** (35%): alternanza delle caratteristiche

- Nel 15% dei casi l'attività psicomotoria è **normale**

Kiely et al, Association between psychomotor activity delirium subtypes and mortality among newly admitted postacute facility. Journ Gerontol 2007;2:174-179

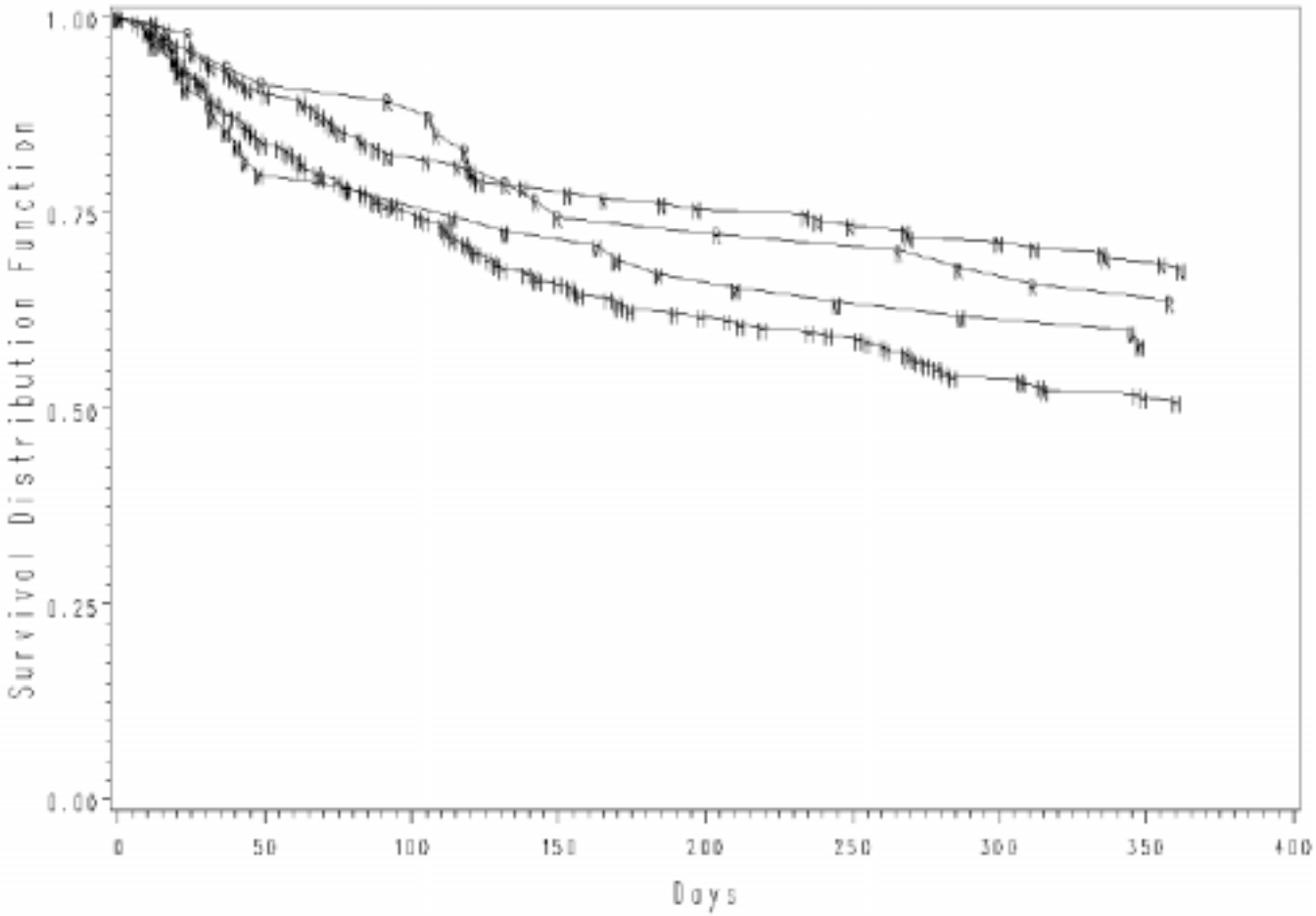
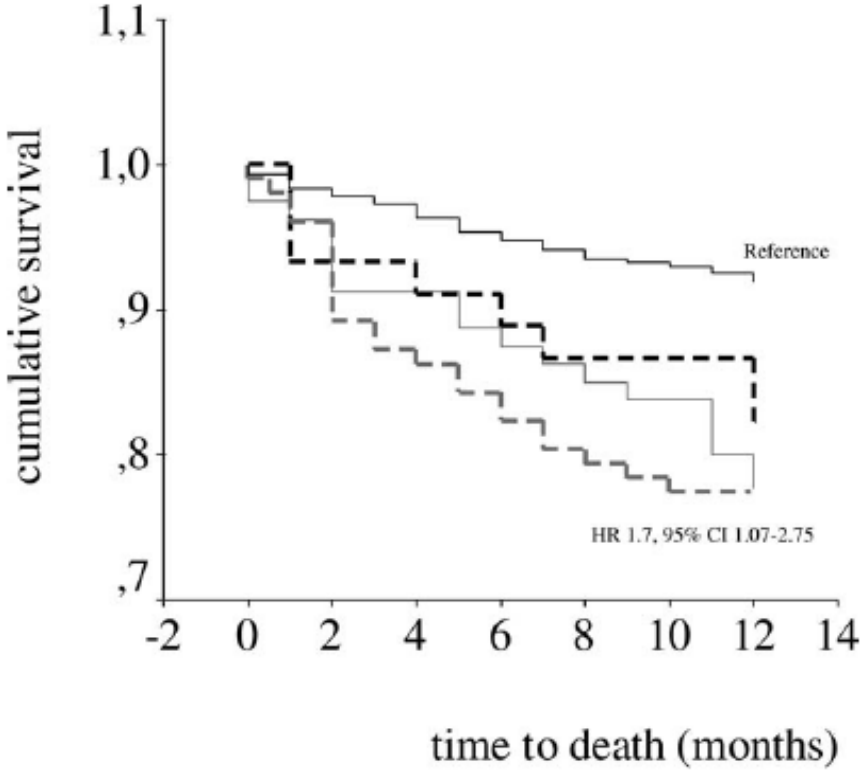


Figure 1. Kaplan–Meier survival curves for the three psychomotor disturbance subtypes (hypoactive, hyperactive, mixed) and the normal (no psychomotor disturbances) psychomotor activity group. Differences in the survival trajectory of the delirium subtypes were statistically significant (log-rank = 10.9; $p = .01$). N = Normal; M = mixed; H = hypoactive; R = hyperactive.



black solid line= no delirium; black dotted line= hyperactive

grey solid line= mixed; grey dotted line= hypoactive

Figure 1. Kaplan-Meier survival curves for the three delirium subtypes (hypoactive, hyperactive, mixed) and individuals without delirium. Hazard ratio (HR) and 95% confidence interval (CI) were computed in a Cox regression model where age, gender, and comorbidity were covariates; those without delirium were the reference group.

Bellelli et al, Journal Gerontology, 2007

EPIDEMIOLOGY

Delirium is common in hospitals and nursing homes. At admission to hospital 10-20 % of elderly (+65) have delirium, and 10-30% develop delirium while at hospital

- Elderly in medical departments 10-25%
- Elderly patients in surgical department 7-52 %
- Elderly patients with hip fractures 20-30 %
- Elderly patients with stroke 13–50 %
- Elderly after coronary surgery 23-34 %
- Patients in ICU (all ages) 40 %
- Nursing home patients 20-40%
- Elderly patients in ICU 70%

Delirium gives poor outcomes

- **LOS doubled**

  Gustafson 1988, Williams-Russo 1992, Jitapunkul 1992, Levkoff 1992, Marcantonio 1994, O'Keeffe and Lavan 1997, McCusker 2003

- **Institutional care 2.8 –7.3 times more frequent**

  Francis 1990, Jitapunkul 1992, Levkoff 1992, Marcantonio 1994, George 1997, O'Keeffe and Lavan 1997

- **Mortality increased**

  Francis 1990, Jitapunkul 1992, Francis and Kapoor 1992, Pompei 1994, George 1997, McCusker 2002

  - In hospital 8-35% (vs 1-8%)
  - At 6 mnts. 15-31% (vs 10-15%)
  - At 12 mnts. 38-48% (vs 14-21%)
  - At 5 years 72% (vs 35%)

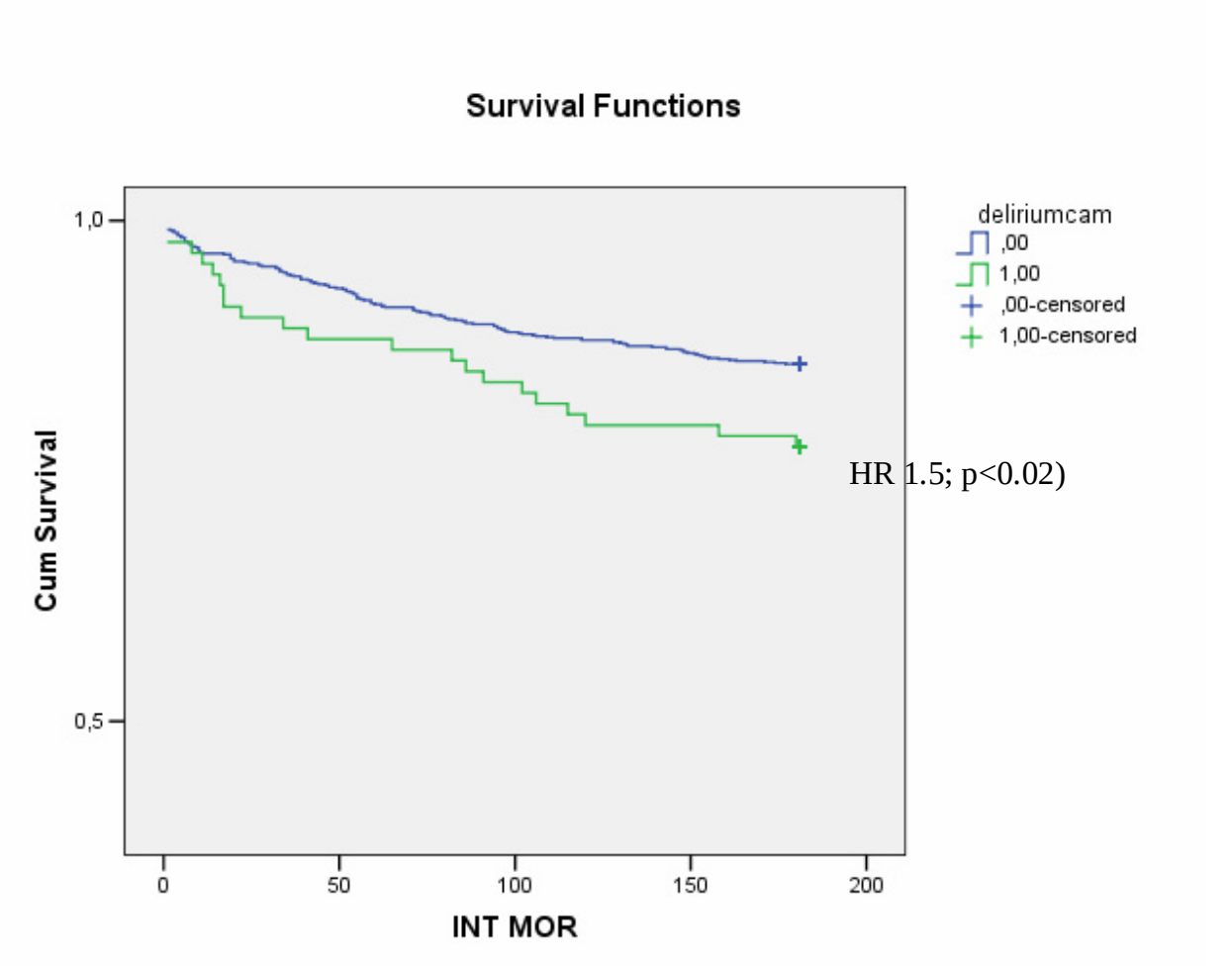
Delirium in 1508 elderly patients consecutively admitted to ACU unit

- Overall prevalence of delirium among patients aged 65 years or more admitted to our ACU was 19.1%
- The length of delirium episode was 3.8±1.8 days.
- Demented patients in delirious group are 41.0% of the sample, while in the total sample of elderly patients the proportion of demented was 13.3%.
- Prevalent delirium was detected in 9.4% of over 65 and 9.8% had an incident delirium

Delirium in elderly admitted to ACU unit

- In the total sample of delirious subjects, the mixed subtype was the more prevalent (48%), while 41% were of hyperactive subtype and 11% of hypoactive.
- In the delirium and dementia group, mixed variant was more prevalent (61%), while hyperactive variant was 34%.
- In patients without dementia, hyperactive variant was 46% while mixed variant was 38%. The differences versus demented patients were not statistically significant.
- In-hospital mortality: 9% vs 5%; OR 1.8, $p<0.01$

Survival curves of the 6-month mortality rate



HR 1.5; p<0.02)

Cox regression model. Comorbidity as covariate

Journal of Gerontology: MEDICAL SCIENCES
2007, Vol. 62A, No. 11, 1306–1309

Delirium Superimposed on Dementia Predicts 12-Month Survival in Elderly Patients Discharged From a Postacute Rehabilitation Facility

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Background. Delirium superimposed on dementia (DSD) is highly prevalent and associated with high mortality among hospitalized elderly patients, yet little is known about the effect of DSD on midterm mortality. The purpose of this study was to assess 12-month survival in patients with DSD and matched groups with dementia alone, delirium alone, or neither delirium nor dementia.

Methods. Among 1278 consecutively admitted elderly participants (aged $\geq$65 years) to our Rehabilitation Unit between January 2002 and May 2005, four matched samples of 47 participants each (DSD, dementia alone, delirium alone, or neither delirium nor dementia) were selected. Matching was based on age, gender, and reason for admission. Postdischarge 12-month survival was assessed in the four groups with Kaplan–Meyer analysis and compared with Cox proportional hazard regression models adjusted for confounders.

Results. Survival was significantly lower for DSD patients than for the other three groups. After adjustment for comorbidity and Barthel Index score before admission, patients with DSD had significantly higher mortality (hazard ratio, 2.3; 95% confidence interval, 1.1–5.5; $p = .04$) than did patients with neither delirium nor dementia.

Conclusions. Demented patients who experienced delirium during hospitalization had a more than twofold increased risk of mortality in the 12 months following discharge than did patients with dementia alone, with delirium alone, or with neither dementia nor delirium.

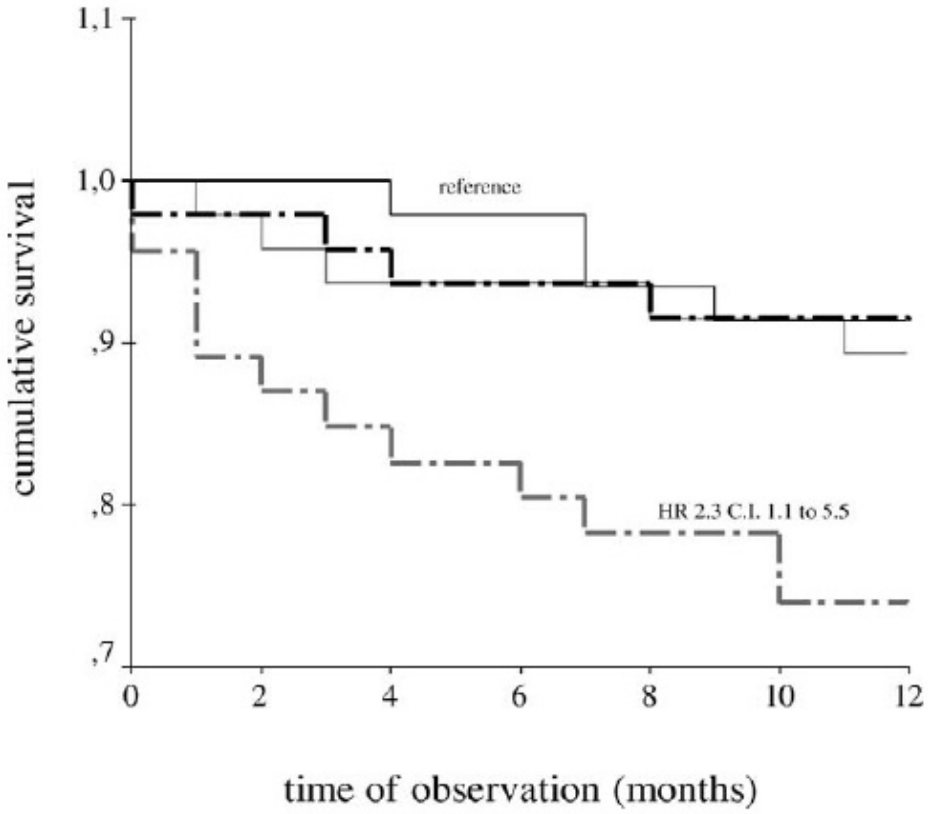


Figure 1. Survival of patients with neither delirium nor dementia, dementia alone, delirium alone, or delirium superimposed on dementia. Hazard ratio (HR) and 95% confidence interval (C.I.) were computed in Cox regression models where comorbidity and Barthel Index before admission were covariates, and patients with neither delirium nor dementia made up the reference group. *Black solid line* = no delirium, no dementia; *black dotted line* = dementia; *grey solid line* = delirium; *grey dotted line* = delirium superimposed on dementia.

Bellelli et al, J Geront, 2007

Rockwood K, Cosway S, et al.

The risk of dementia and death after delirium.

Age Ageing. 1999 Oct;28(6):551-6.

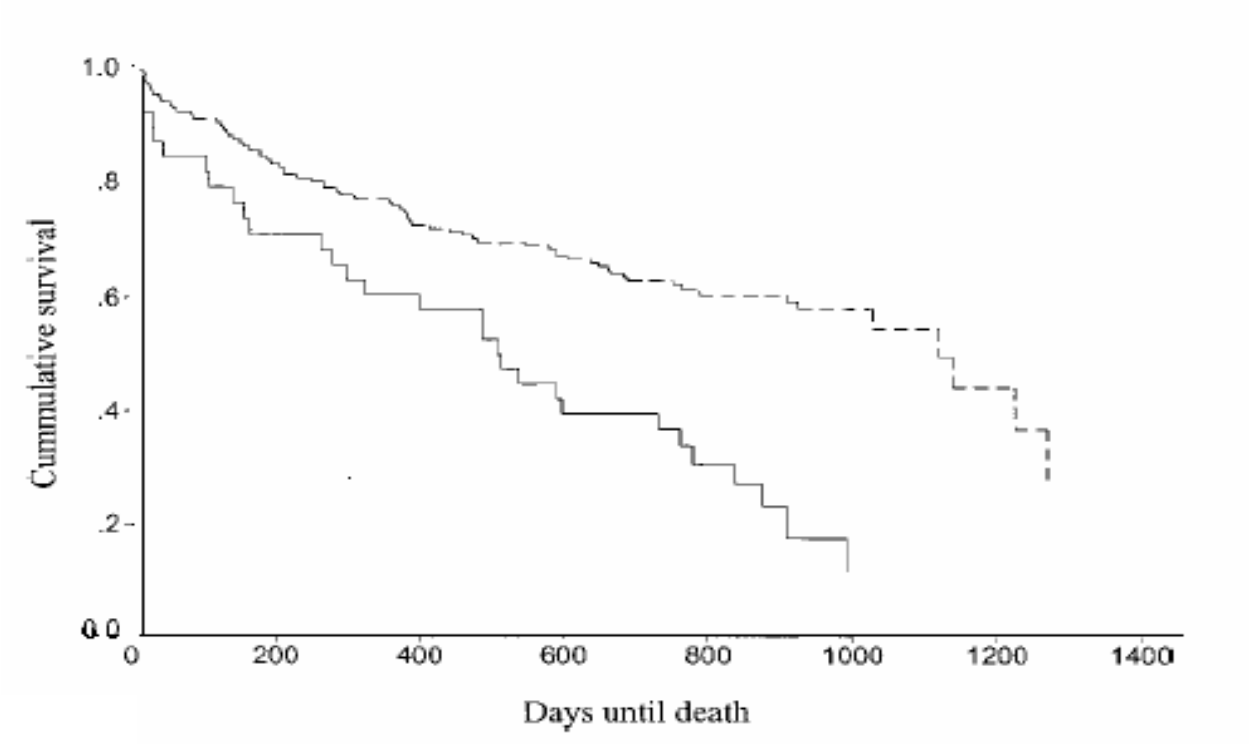


Figure 2. Survival time for subjects with (—) and without (- - -) delirium at baseline.

COMPLICANZE INTRAOSPEDALIERE

Il delirium è il più forte predittore di rischio di sviluppare una complicanza durante il ricovero ospedaliero

	delirium N/N (%)	No delirium N/N (%)	unadjusted odds ratios (95%CI)
urinary incontinence	48/78 (62)	38/128 (30)	3.8 (2.1-6.9)
falls	19/94 (20)	9/131 (7)	3.4 (1.5-7.7)
pressure sores	6/83 (7)	2/119 (2)	4.5 (0.9-23.2)
any complications	56/94 (60)	44/131 (34)	2.7 (1.7-5.0)

J Gerontol, 2001

DECLINO FUNZIONALE

Pazienti con delirium durante il ricovero ospedaliero risultano alla dimissione funzionalmente più compromessi:

Gruppo con delirium:	26% peggiora 55% stazionario 19% migliora
Gruppo senza delirium:	12% peggiora 60% stazionario 28% migliora

Delirium: predittore di peggioramento funzionale legato all'ospedalizzazione

J Am Geriatr Soc 1997

• Delirium in elderly admitted to ACU unit

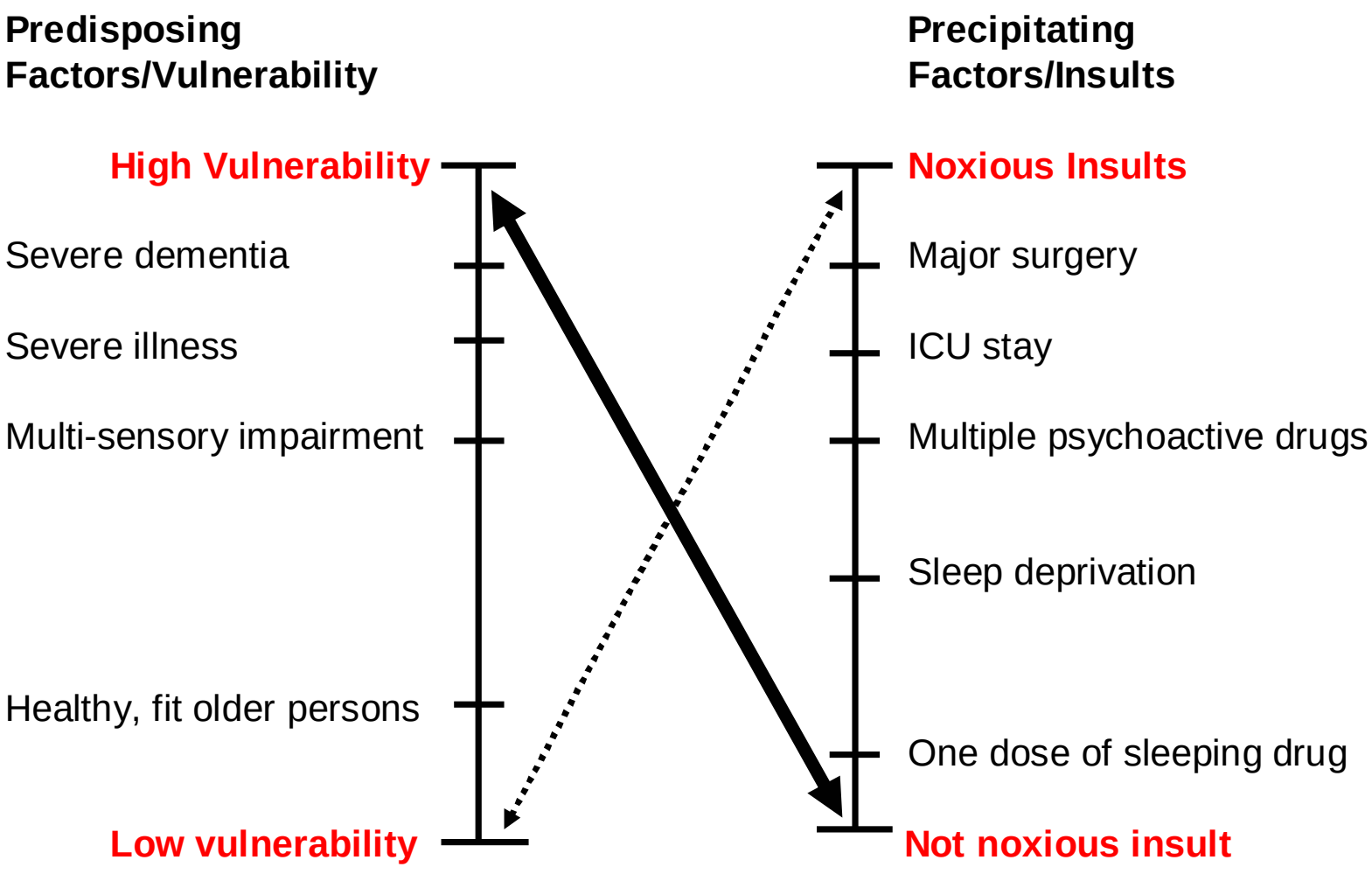
Istituzionalizzazione a 6 mesi:

18% vs 7.4%; OR 2.4, $p<0.001$

Utilizzo di una badante a 6 mesi:

33.3% vs 13%; OR 2.6, $p<0.001$

- Il delirium **NON** è un processo benigno
- Il 50% circa dei pazienti con delirium non ottiene una diagnosi corretta



Inouye S JAMA 1996

Table 2. Predisposing Factors for Delirium.

Demographic characteristics
Age of 65 years or older
Male sex
Cognitive status
Dementia
Cognitive impairment
History of delirium
Depression
Functional status
Functional dependence
Immobility
Low level of activity
History of falls
Sensory impairment
Visual impairment
Hearing impairment
Decreased oral intake
Dehydration
Malnutrition
Drugs
Treatment with multiple psychoactive drugs
Treatment with many drugs
Alcohol abuse
Coexisting medical conditions
Severe illness
Multiple coexisting conditions
Chronic renal or hepatic disease
History of stroke
Neurologic disease
Metabolic derangements
Fracture or trauma
Terminal illness
Infection with human immunodeficiency virus

Table 3. Precipitating Factors or Insults That Can Contribute to Delirium.

Drugs
Sedative hypnotics
Narcotics
Anticholinergic drugs
Treatment with multiple drugs
Alcohol or drug withdrawal
Primary neurologic diseases
Stroke, particularly nondominant hemispheric
Intracranial bleeding
Meningitis or encephalitis
Intercurrent illnesses
Infections
Iatrogenic complications
Severe acute illness
Hypoxia
Shock
Fever or hypothermia
Anemia
Dehydration
Poor nutritional status
Low serum albumin level
Metabolic derangements (e.g., electrolyte, glucose, acid–base)
Surgery
Orthopedic surgery
Cardiac surgery
Prolonged cardiopulmonary bypass
Noncardiac surgery
Environmental
Admission to an intensive care unit
Use of physical restraints
Use of bladder catheter
Use of multiple procedures
Pain
Emotional stress
Prolonged sleep deprivation

Inouye S, NEJM, 2006

Delirium in the elderly can be prevented!

	N	R/NR	abs.risc OR	severity	LOS
Gustafson 1991	103 +111	NR	-13.7%	⇓⇓	11.6 v.s. 17.4
Inouye 1999	852	NR	-5.1% OR 0.6	⇓⇓	±
Marcantonio 2001	126	R	-18% OR 0.6	⇓	±
Milisen 2001	120	NR	±	⇓	±

Prevention of delirium; intervention program

1) Gustafson 1991, 2) Inouye 1999, 3) Marcantonio 2001, 4) Milisen 2001

	1)	2)	3)	4)
cognition, orientation	+	+	+	+
mobility		+	+	+
eyes and ears		+	+	+
sleep - wake disorders		+		+
fluid / electrolytes		+	+	+
pain relief			+	+
geriatric consultation	+		+	+
early surgery	+			
CNS oxygenation	+		+	
prevention of complications	+		+	
medication check - up			+	
bladder and bowel	+		+	
nutrition			+	

A Multifactorial Intervention to Reduce Prevalence of Delirium and Shorten Hospital Length of Stay

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J Am Geriatr Soc 53:18–23, 2005.

- **CONCLUSION**: A multifacorial intervention designed to reduce delirium in older adults was associated with improved psychotropic medication use, less delirium and hospitals savings

Haloperidol Prophylaxis for Elderly Hip-Surgery Patients at Risk for Delirium: A Randomized Placebo-Controlled Study

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INTERVENTION: Haloperidol 1.5 mg/d or placebo was started preoperatively and continued for up to 3 days postoperatively.

CONCLUSION: Low-dose haloperidol prophylactic treatment demonstrated no efficacy in reducing the incidence of postoperative delirium. It did have a positive effect on the severity and duration of delirium. Moreover, haloperidol reduced the number of days patients stayed in the hospital,and the therapy was well tolerated.

Donepezil in the Prevention and Treatment of Post-Surgical Delirium

Benjamin Liptzin, M.D., Agnes Laki, M.P.H., C.H.E.S.
Jane L. Garb, M.S., Richard Fingeroth, M.D.
Robert Krushell, M.D.

Objective: *Delirium is a frequent complication of major surgery in older persons. The authors evaluated the possible benefit of donepezil versus placebo in the prevention and treatment of postoperative delirium in an older population without dementia undergoing elective total joint-replacement surgery.* **Methods**: *A sample of 80 patients participated in this randomized, double-blind, placebo-controlled trial of donepezil. Each participant was evaluated before surgery and then received donepezil or placebo for 14 days before surgery and 14 days afterward. Postoperative delirium was assessed with the Delirium Symptom Interview, Confusion Assessment Method, daily medical record, nurse-observation reviews, and DSM-IV diagnostic criteria for delirium. Subsyndromal delirium was also assessed for each participant.* **Results**: *Delirium, diagnosed by DSM-IV criteria, was found on at least 1 postoperative day in 18.8% of subjects, but there were no significant differences between the donepezil and placebo groups. When delirium was present, it lasted only 1 day, and there was no difference between the groups. Subsyndromal delirium was found on at least 1 postoperative day for 68.8% of subjects, and, when this occurred, lasted 2 days or less, on average. There was no difference between the groups in the occurrence or duration of subsyndromal delirium. There was no difference between the groups in disposition to home or to another facility.* **Conclusions**: *This pilot study was unable to demonstrate a benefit for donepezil in preventing or treating delirium in a relatively young and cognitively-intact group of elderly patients undergoing elective orthopedic surgery. Furthermore, postoperative delirium was not a major problem in this population.* (Am J Geriatr Psychiatry 2005; 13:1100–1106)

Cochrane Database Syst Rev. 2007 Apr 18;(2):CD005563.

Interventions for preventing delirium in hospitalised patients

Siddiqi N, Stockdale R, Britton A, Holmes J.

- Research evidence on effectiveness of interventions to prevent delirium is sparse.
- **Programme of proactive geriatric consultation** may reduce delirium incidence and severity in patients undergoing surgery for hip fracture.
- **Prophylactic low dose haloperidol** may reduce severity and duration of delirium episodes and shorten length of hospital admission in hip surgery.
- Further studies of delirium prevention are needed.

CLINICAL CHARACTERISTICS AND RISK FACTORS OF DELIRIUM IN DEMENTED AND NOT DEMENTED ELDERLY MEDICAL INPATIENTS

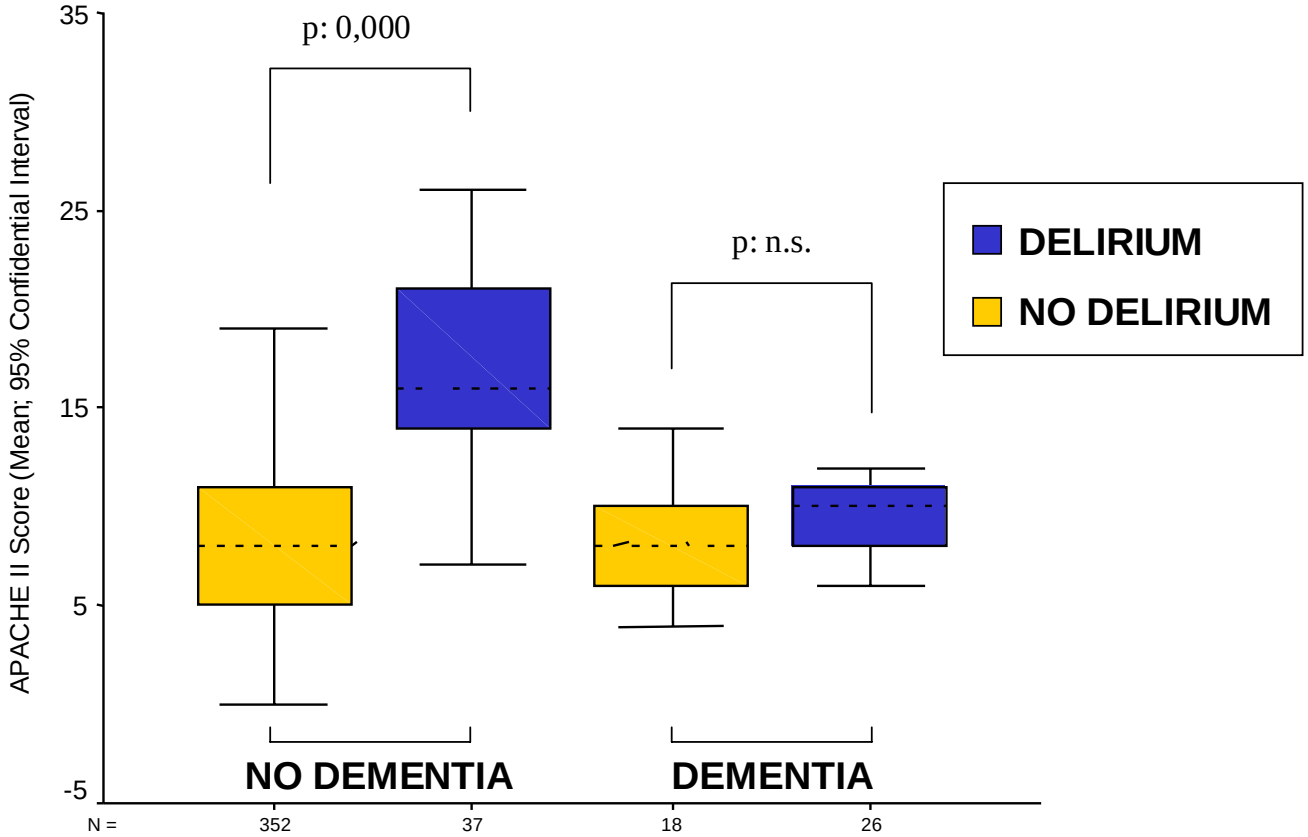
A. MARGIOTTA[1,2], A. BIANCHETTI[1,2], P. RANIERI[1,2], M. TRABUCCHI[2,3]

Table 1
Clinical Variables in a Population of 330 Elderly Inpatients Admitted to an ACU, According to the Absence or the Presence of Delirium.

	Not delirious (n = 267)	Delirious (n = 63)	p*
Age (years)	79.8 (8.5)	81.6 (7.2)	.112
Hospital stay (days)	9.3 (2.6)	10.5 (4.5)	.004
Barthel Index (one month before admission)[1]	80.7 (29.8)	70.7 (21.7)	.013
Barthel Index (on admission)[1]	65.2 (36.8)	30.6 (21.6)	.001
Functional Loss[2]	15.3 (21.7)	40.1 (19.0)	.001
Instrumental Activities of Daily Living (functions lost)[1]	3.2 (3.1)	4.5 (2.4)	.002
Mini Mental State Examination[1]	22.1 (7.0)	16.9 (6.8)	.000
Acute Physiology Age and Chronic Health Evaluation[2]	8.9 (5.0)	14.1 (5.6)	.000

Mean; Standard Deviation; Functional Loss = Barthel Index score one month before admission – Barthel Index score on admission
1 Student t test for unpaired samples; 2 Lower score indicates grater severity; 3 Higher score indicates greater severity

RISK FACTORS FOR DELIRIUM ACCORDING TO DIAGNOSIS OF DEMENTIA



A. Margiotta et al., 2006

The NEW ENGLAND JOURNAL of MEDICINE

REVIEW ARTICLE

CURRENT CONCEPTS

Delirium in Older Persons

Sharon K. Inouye, M.D., M.P.H.

N Engl J Med 2006;354:1157-65.

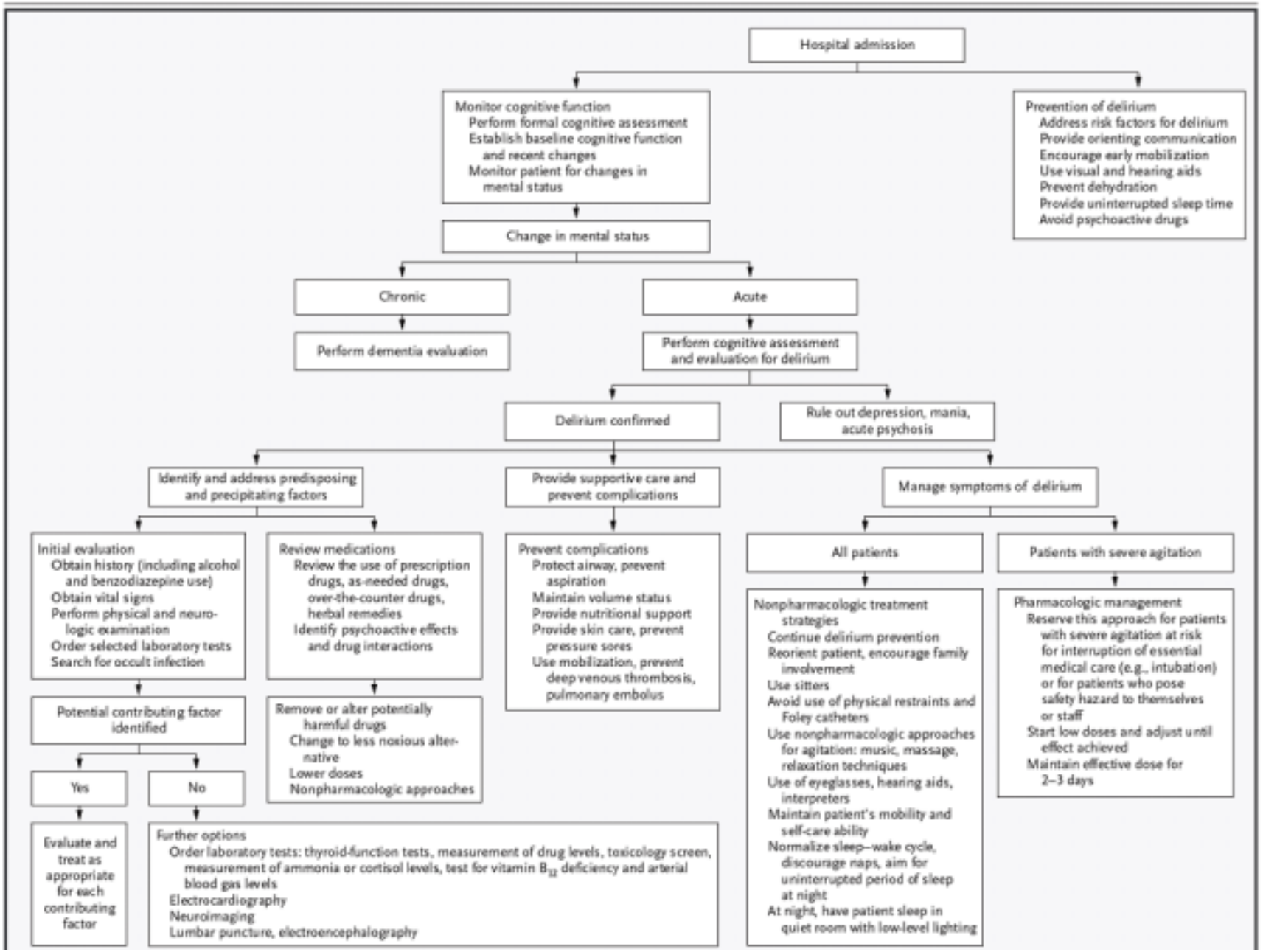

Hospital admission
Monitor cognitive function
Perform formal cognitive assessment
Establish baseline cognitive function and recent changes
Monitor patient for changes in mental status
Prevention of delirium
Address risk factors for delirium
Provide orienting communication
Encourage early mobilization
Use visual and hearing aids
Prevent dehydration
Provide uninterrupted sleep time
Avoid psychoactive drugs
Change in mental status
Chronic
Acute
Perform dementia evaluation
Perform cognitive assessment and evaluation for delirium
Delirium confirmed
Rule out depression, mania, acute psychosis
Identify and address predisposing and precipitating factors
Provide supportive care and prevent complications
Manage symptoms of delirium
Initial evaluation
Obtain history (including alcohol and benzodiazepine use)
Obtain vital signs
Perform physical and neurologic examination
Order selected laboratory tests
Search for occult infection
Review medications
Review the use of prescription drugs, as-needed drugs, over-the-counter drugs, herbal remedies
Identify psychoactive effects and drug interactions
Prevent complications
Protect airway, prevent aspiration
Maintain volume status
Provide nutritional support
Provide skin care, prevent pressure sores
Use mobilization, prevent deep venous thrombosis, pulmonary embolus
All patients
Patients with severe agitation
Potential contributing factor identified
Remove or alter potentially harmful drugs
Change to less noxious alternative
Lower doses
Nonpharmacologic approaches
Nonpharmacologic treatment strategies
Continue delirium prevention
Reorient patient, encourage family involvement
Use sitters
Avoid use of physical restraints and Foley catheters
Use nonpharmacologic approaches for agitation: music, massage, relaxation techniques
Use of eyeglasses, hearing aids, interpreters
Maintain patient's mobility and self-care ability
Normalize sleep–wake cycle, discourage naps, aim for uninterrupted period of sleep at night
At night, have patient sleep in quiet room with low-level lighting
Pharmacologic management
Reserve this approach for patients with severe agitation at risk for interruption of essential medical care (e.g., intubation) or for patients who pose safety hazard to themselves or staff
Start low doses and adjust until effect achieved
Maintain effective dose for 2–3 days
Yes
No
Evaluate and treat as appropriate for each contributing factor
Further options
Order laboratory tests: thyroid-function tests, measurement of drug levels, toxicology screen, measurement of ammonia or cortisol levels, test for vitamin B_{12} deficiency and arterial blood gas levels
Electrocardiography
Neuroimaging
Lumbar puncture, electroencephalography

Table 4. Pharmacologic Treatment of Delirium.

Class and Drug	Dose	Adverse Effects	Comments
Antipsychotic			
Haloperidol	0.5–1.0 mg twice daily orally, with additional doses every 4 hr as needed (peak effect, 4–6 hr) 0.5–1.0 mg intramuscularly; observe after 30–60 min and repeat if needed (peak effect, 20–40 min)	Extrapyramidal symptoms, especially if dose is >3 mg per day Prolonged corrected QT interval on electrocardiogram Avoid in patients with withdrawal syndrome, hepatic insufficiency, neuroleptic malignant syndrome	Usually agent of choice Effectiveness demonstrated in randomized, controlled trials[20,37] Avoid intravenous use because of short duration of action
Atypical antipsychotic			
Risperidone	0.5 mg twice daily	Extrapyramidal effects equivalent to or slightly less than those with haloperidol Prolonged corrected QT interval on electrocardiogram	Tested only in small uncontrolled studies Associated with increased mortality rate among older patients with dementia
Olanzapine	2.5–5.0 mg once daily		
Quetiapine	2.5–5.0 mg once daily		
Benzodiazepine			
Lorazepam	0.5–1.0 mg orally, with additional doses every 4 hr as needed*	Paradoxical excitation, respiratory depression, oversedation	Second-line agent Associated with prolongation and worsening of delirium symptoms demonstrated in clinical trial[37] Reserve for use in patients undergoing sedative and alcohol withdrawal, those with Parkinson's disease, and those with neuroleptic malignant syndrome
Antidepressant			
Trazodone	25–150 mg orally at bedtime	Oversedation	Tested only in uncontrolled studies

* Intravenous use of lorazepam should be reserved for emergencies.

DELIRIUM E DELIRIUM SUBSINDROMICO

Table 5. Comparison of the Prevalence of DSI Delirium Symptoms Across Delirium Subgroups

Delirium Symptoms	Delirium (n = 335)	Subsyndromal (2^+ symp.; n = 271)	Subsyndromal (1 symp.; n = 850)	No Delirium (n = 696)	p Value
Disorientation (%)	91.0	65.3	41.9	14.7	.0001
Sleep disturbance (%)	59.4	42.4	43.5	46.9	.0001
Perceptual disturbance (%)	37.1	17.8	8.0	6.2	.0001
Attention disturbance (%)*	100.0	94.8	78.9	0.0	.0001
Consciousness disturbance (%)*	38.2	6.3	0.9	0.0	.0001
Incoherent speech (%)*	93.4	70.1	16.8	0.0	.0001
Abnormal psychomotor activity (%)	64.5	31.7	21.4	11.0	.0001
Fluctuating behavior (%)*	81.8	23.0	0.8	0.0	.0001

Journal of Gerontology: MEDICAL SCIENCES
2003, Vol. 58A, No. 5, 441–445

Delirium subsindromico

	No delirium (n: 145)	**Delirium Subsindromico** (n: 48)	p*	**Delirium** (n: 18)	p**
Età (anni)	78,9±7,4	81,8±8,2	0,022	84,2±5,3	n.s.
Degenza (giorni)	7,9±4,0	9,7±6,3	0,027	8,4±2,9	n.s.
MMSE (Mini Mental State Examination)	22,6±5,1	18,6±5,4	0,000	12,3±6,2	0,002
GDS (Geriatric Depression Scale)	4,6±3,4	5,9±3,6	n.s.	6,0±3,6	n.s.
IADL (funzioni perse)	3,1±3,1	4,9±3,0	0,000	6,5±2,1	0,050
Barthel Index premorboso	86,1±21,7	66,6±29,4	0,000	46,7±31,1	0,019
Barthel Index ingresso	69,7±32,3	31,2±30,1	0,000	11,7±17,4	0,002
Barthel Index dimissione	80,4±26,7	53,5±32,3	0,000	29,7±25,6	0,008
Declino funzionale (BI premor.-BI ingr.)	16,4±20,7	35,4±28,5	0,000	35,0±26,6	n.s.
APS (Acute Physiologic Score)	3,7±3,2	5,0±4,4	0,032	5,0±4,4	n.s.
Charlson Index	3,5±1,8	4,4±2,4	0,007	5,6±3,3	n.s.
N° farmaci (terapia al domicilio)	5,2±2,8	4,5±2,6	n.s.	5,5±2,3	n.s.
Demenza (%)	6,8	36,6	0,000	77,7	0,000

p* T-Test per variabili indipendenti fra No delirium e DSS, tranne che per la voce “Demenza”: test Chi-quadrato. p** T-Test per variabili indipendenti fra DSS e D, tranne che per la voce “Demenza”: test Chi-quadrato.

Le “10 regole d’oro” da rispettare per una corretta gestione diagnostico-terapeutica del delirium.

1) Diagnosticare il delirium utilizzando i criteri del DSM IV
2) Il riconoscimento del delirium può essere facilitato dall’uso routinario di strumenti che valutino lo stato mentale (MMSE, SPSMQ o altri). La somministrazione ripetuta a distanza di tempo può facilitare il riconoscimento di un delirium incidente
3) Deve essere conosciuto lo stato cognitivo e funzionale pre-morboso. Questa informazione è ottenibile dai famigliari o dai badanti.
4) I fattori predisponenti (es: demenza, malattia severa, deprivazione sensoriale, alcoolismo) devono essere identificati e tenuti sempre in considerazione
5) I fattori precipitanti (infezioni, somministrazione o sospensione di farmaci) devono essere trattati e prevenuti
6) La contenzione (fisica e farmacologica) deve essere evitata
7) I farmaci psicotropi devono essere utilizzati solo in presenza di potenziali rischi del paziente per sé o per gli altri. Deve essere utilizzata un’unica molecola (preferibilmente l’aloperidolo) alla minima dose efficace
8) La terapia farmacologica deve essere periodicamente rivista
9) L’ambiente deve essere il più possibile confortevole, tranquillo e con adeguata illuminazione. Orologi, calendari e fotografie devono essere presenti per favorire l’orientamento
10) Il trattamente deve essere di tipo multidisciplinare e deve essere formulato un piano di dimissione per la cura del soggetto al proprio domicilio e per il supporto dei caregivers

Bianchetti A et al, 2004

Conclusioni

- Il delirium è una sindrome con espressioni cliniche eterogenee (ipo, iper, misto, subsindromico…), il cui significato clinico in termini prognostici può essere chiarito solo dopo una attenta ed approfondita valutazione
- Il termini generali il delirium si associa ad una prognosi clinica peggiore
- Il delirium ipocinetico tende ad essere misconosciuto, ma sembra associarsi a prognosi peggiore
- Il trattamento si va sempre più arricchendo di indicazioni non farmacologche e farmacologiche, anche se la mancanza di ampi trial rende “empirico” l’approccio al singolo paziente