DEMENTIA VS DELIRIUM IN THE GERIATRIC PATIENT

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June 3, 2016

NO DISCLOSURES

Delirium

• Occurs in:
  • 2.5 million elderly patients in the US each year
  • 50% of general hospital patients at the end of life
  • 30-40% of older medical patients
  • 15-50% of surgical patients
• It is associated with:
  • increased morbidity
  • increased length of stay
  • poorer functional outcomes
  • increased risk of nursing home placements
  • increased costs
Delirium

- New onset behavior changes requires careful evaluation of pain or other sources of distress, including physiologic compromise.
- In the absence of self report, observation of behavior is a valid approach to pain assessment.
- Delirium can be either hyperactive (agitation, restlessness pulling on lines or emotional liability) or hypoactive delirium (flat affect, withdrawal, apathy lethargy decreased responsiveness) or a combination of both.
- A multifactor approach is recommended that combines direct observation, family caregiver input, consideration of known pain producing conditions, and evaluation of response to treatment.

Predisposing Risk Factors

- Present on admission
  a) sensory impairment
  b) history of cognitive impairment
  c) sleep deprivation
  d) immobility
  e) dehydration
- Age,
- Number and severity of co-morbid medical conditions

Precipitating Factors

- Acute hospitalization – unfamiliar environment
- Infections
- Use of a bladder catheter
- PAIN
- Procedures involving instrumentation, sensory impairment, and immobility.
DEMENTIA VS DELIRIUM
What can cause it?

- D Dementia
- E Electrolyte disorders
- L Lung Liver heart Kidney Brain
- I Infection
- R RX drug
- I Injury PAIN Stress
- U Unfamiliar environment
- M Metabolic

Delirium vs. Dementia Differences

<table>
<thead>
<tr>
<th>CHARACTERISTICS</th>
<th>DELERIUM/DEMENTIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>ONSET</td>
<td>ACUTE/INSIDIOUS</td>
</tr>
<tr>
<td>COURSE</td>
<td>FLUCTUATING/STABLE</td>
</tr>
<tr>
<td>DURATION</td>
<td>HRS/WEEKS/MONTHS/YRS</td>
</tr>
<tr>
<td>ATTENTION</td>
<td>FLUCTUATES/NORMAL</td>
</tr>
<tr>
<td>PERCEPTION</td>
<td>HALLUCINATIONS/NORMAL</td>
</tr>
<tr>
<td>SLEEP/WAKE</td>
<td>DISRUPTED/FRAGMENTED</td>
</tr>
</tbody>
</table>

STATISTICS

- Studies done show that 80% of residents in long term facilities may experience chronic pain daily.
- 25%-50% of community dwelling older adults experience pain.
- 20-75% of patients with cancer are experiencing pain.
Myths vs. Facts

- **Myth:** Older patients don’t feel pain as acutely as younger adults.
- **Fact:** Older patients can experience pain the same way younger patients do but can’t report it.
- **Myth:** Pain is a natural consequence of getting older, and many patients feel that pain is just part of getting older.
- **Fact:** Acceptance of pain as part of getting older can diminish a patients quality of life.

PROPER MANAGEMENT OF PAIN TO AVOID SUPERIMPOSED DELIRIUM

- PAIN SCALES FOR THE COGNITIVELY IMPAIRED
- PAINAD
- SPEAK WITH FAMILIES/ CARETAKERS
- ASSUME PAIN/AFTER TRAUMA
- PHYSICAL EXAM

UNIVERSAL PAIN ASSESSMENT TOOL

This pain assessment tool is intended to help patient care providers assess pain according to individual patient needs. Explain and use 0-10 Scale for patient self-assessment. Use the face or behavioral observations to interpret expressed pain when patient cannot communicate his/her pain intensity.

WONG-BAKER FACIAL EXPRESSION SCALE:

0 = No pain
1-2 = Slightly inconvenienced
3-4 = Slightly inconvenienced
5-6 = Moderately inconvenienced
7-8 = Quite inconvenienced
9-10 = Totally inconvenienced

ACTIVITY TOLERANCE SCALE:

0 = Normal
1 = Can be ignored
2 = Interferes with tasks
3 = Interferes with concentration
4 = Interferes with basic needs
5 = Hoped for

HOSPITALIZED REQUIRED
Case 1

89 year old female PMH
Dementia and legally blind,
falls at **assisted living** sustains a
hip fracture requiring ORIF.

Case 1, cont.

- Palliative consult called one day after admission.
- Assessment → non verbal, responding only to
tactile stimuli.
- Is it advanced dementia or delirium?
- How long do you think length of stay was?
- What do you think she scored on the PAINAD?
• Case 2

• 92 year old male from assisted living falls while trying to get away from two female residents; falls on one of the woman’s walkers.
• PMH: PVD, Dementia, DM, CAD and COPD.

• Case 2, cont.

• Post-op, the patient becomes combative, hitting, and spitting at staff.
• All pain medications held. Haloperidol (Haldol) given.
• Psych consult called.
• Is this advanced dementia or delirium?
• Length of stay?
• What do you think he scored on the PAINAD?

• Case 3

• 70 year old female who lives at home and alone, presents with change in mental status, screaming in pain.
• PMH: HTN, Neuropathy.
• Admitted with gallstones, hyponatremia, anemia and anorexia.
Case 3, cont.

- New diagnosis of DEMENTIA
- What do you think?
- Is this really a newly diagnosed Dementia making her act out or acute delirium?
- What did her sons think?
- What do you think she scored on the PAINAD?

Case 4

- 85 year old male from home presented with family with a change in mental status (hallucinations), multiple ecchymotic areas b/l knees, left eye etc.
- PMH: Lewy Body Dementia, with behavior disturbances, falls, Osteoarthritis.

Case 4, cont.

- Haloperidol (Haldol) given; which is indicated for the treatment of delirium but not for dementia with psychosis.
- Interview with family → he was driving one week prior to admission.
- Primary Doctor tells family his Lewy Body Dementia has advanced and he needs nursing home placement.
- Considered an unsafe discharge.
- What do you think?
- Lewy Body Dementia or acute Delirium?
- What do you think he scored on the PAINAD?
Case 5

79 year old female presents to ER with SDH s/p fall in facility, currently not eating, severely depressed, continuously crying, unable to redirect.

Case 5, cont.

Primary team is Trauma Surgery.
Palliative consult was called → diagnosed with acute delirium.
Diagnoses:
1. Depression
2. Neuropathic pain
3. Constipation

ICU Delirium

Incidence of 70-87% of the elderly patients admitted to the ICU.
Costs of associated delirium in the ICU between 4 billion and 16 billion dollars a year.
This form of acute brain dysfunction is associated with:
• Increased length of stay.
• Prolonged time on ventilator.
• Long-term neuropsychological deficits.
• Mortality.
• CAM (confusion assessment method) or the ICDSC Intensive Care Delirium Screening checklist.
• Case 6

• 90 year old Female who fell at home sustaining a SDH presented to ER admitted to ICU.

Case 6, cont.

• How did we get this patient back to her baseline mental state and functional status?

REFERENCES

3. Delirium: Diagnosis, Prevention and Management [Internet].
5. National Clinical Guideline Centre (UK).
Thank You!