VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: Delirium matters

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Being admitted unexpectedly to hospital is depersonalising and distressing. This is compounded for the one inpatient in eight who has delirium.¹ Delirium affects 20-30% of over 65s during acute admission.² We should do more to prevent delirium, ensure that we don't miss it, to reverse it, explain it, and minimise its impact. Clinical staff need support to do this.

Risk increases if you're older and frailer. Add existing sensory or cognitive impairment, transit through several busy, noisy wards, and contact with numerous unfamiliar staff.

Delirium carries high mortality and morbidity and is a red flag for potentially serious illness. It's characterised by acute onset over 1-2 days, a fluctuating course, and disturbances of cognition, perception, or consciousness.³ The symptoms of hyperactive delirium can be terrifying for patients—disorientation, restless distractibility, hallucinations, and paranoid misperceptions. Relatives visiting may be similarly distressed and bewildered at witnessing this (a patient's story: <http://bit.ly/delirumpatient>).⁴

Meanwhile, hypoactive delirium—leaving patients stuporous and withdrawn, yet still distressed—is less dramatic and is more easily missed or misattributed to old age or dementia.

If a patient is not already delirious on admission, precipitants include infection, dehydration, metabolic disturbance, pain, constipation, urinary retention, surgery and anaesthetic,⁵ side effects from many drugs, and withdrawal from others.⁶

Awareness of this problem is growing despite failure to teach medical students enough about the frailty related syndromes they're increasingly likely to encounter.⁷ For such a common, serious problem, which can often be prevented using systematic approaches,⁸ delirium still has to gain parity with falls, thrombosis, and infection, which attract mandatory incident reporting as preventable harms.

The National Institute for Health and Care Excellence has produced excellent guidelines and quality standards.⁹ Health Improvement Scotland has a national programme of quality improvement for older people in acute care,¹⁰ including the "Think delirium" resource and several exemplar websites.¹¹ The Royal College of Psychiatrists has excellent information leaflets for families.¹² Once delirium has been diagnosed, we can do

much through medical and nursing interventions to identify and reverse the underlying cause, modify its course, and minimise its impact.^{2,3}

Some pleas, however: explain delirium sensitively and reassuringly in understandable language. Have systems to screen for people at highest risk and to target prevention. Use simple, validated tools such as 4AT to identify most cases.¹³ Don't cause avoidable delirium complacently through poor quality care or treatment.

Although delirium and dementia often coexist, don't label delirium as new or progressive dementia. And don't make premature decisions on future care while patients are still delirious.

Finally, don't lazily label patients as having "acopia,"¹⁴ and be especially wary of blaming a urinary tract infection: UTI, or "acute trimethoprim deficiency," can be the cause of delirium—but often it's not.¹⁵

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