PSYCHOTROPICS AND DELIRIUM: WHAT TO GIVE AND WHAT TO TAKE?

João Lopes¹, Frederica Passos², Miguel Constante², Carlos Malheiro¹, Maria João Heitor²

1 Psychiatry and Mental Health Department, Espírito Santo Hospital, Évora, Portugal

2 Psychiatry and Mental Health Department, Beatriz Ângelo Hospital, Loures, Portugal

Objectives

To assess psychopharmacological management of delirium.

Material and Methods

Clinical case presentation and nonsystematic literature review on this topic.

Background and Aims

Delirium is a common, life-threatening, multiethiological syndrome that remains underrecognized and therefore mistreated, representing one of the most frequent referral reasons for liaison psychiatry in the general hospital.

Psychopharmacological treatment of this disorder has been subject of debate, therefore to assess this type of intervention and its correct use is of utmost importance.

Results

Case Report

- 89-year-old man
- Previously diagnosed with early stage dementia but living independently, with no other relevant medical history, prior to admission.
- Medicated with olanzapine 10mg, galantamine 6mg and nebivolol 10mg.
- Admitted with Community Acquired Pneumonia, which was complicated with multiorgan failure, culminating in septic shock and admission to ICU.
- 10th day of admission: referred to Liaison Psychiatry, due to psychomotor agitation

Management of Delirium

The resolution of Delirium arises with the identification and treatment of the cause, being this the focal point of delirium management.

Several studies suggest that there is **no benefit** for the use of antipsychotic Vs placebo in the **PREVENTION** of delirium. To date, evidence supporting the use of antipsychotics in delirium remains elusive, other than when needed to control the symptoms of agitation.

Stop unnecessary medication, namely the **low-potency antipsychotics** and **anticholinergic drugs**.

Consider switching drugs that increase QT interval.

Avoid any medications associated with precipitating delirium (eg, **high-dose opioids, benzodiazepines, antihistamines, dihydropyridines**).

Benzodiazepines should not be used as first-line treatment of delirium-associated agitation.

Haloperidol should be considered for **first-line treatment** for agitation: IV, if cardiac monitoring is possible, or IM/PO;

If QT interval is increased, consider atypical antipsychotics (olanzapine, risperidone or quetiapine).

Start slow, go slow.

Conclusions

This case and review highlights the importance of delirium in the general hospital setting, its prevention, management and the specific role of psychotropic medication within this syndrome's symptom monitoring and control.

References

Vardi K, Harrington CJ. Delirium: treatment and prevention. R I Med J (2013). 2014;97(6):24–8.
Siddiqi N, Stockdale R, Britton AM, Holmes J. Interventions for preventing delirium in hospitalised non-ICU patients (Review). Cochrane Rev. 2016;(3):1469–93.
Evensen S, Saltvedt I, Lydersen S, Wyller TB, Taraldsen K, Sletvold O. Environmental factors and risk of delirium in geriatric patients: an observational study. BMC Geriatr. 2018;18(1):1–8.
Markowitz JD, Narasimhan M. Delirium and antipsychotics: a systematic review of epidemiology and somatic treatment options. Psychiatry (Edmont). 2008;5(10):29–36.
Thom RP, Mock CK, Teslyar P. Delirium in hospitalized patients: Risks and benefits of antipsychotics. Cleve Clin J Med. 2017;84(8):616–22.

Disclosure

Presented at the 19th WPA Congress of Psychiatry | 21-24 August. 2019, Lisbon
Contact: joaogsmlopes@gmail.com

The author reports no potential conflicts of interest