# Delirium

**Introduction:** Delirium is an acute organic mental disorder characterized by impairment of consciousness, disorientation and disturbances in perception and restlessness.

**Delirium** is a disturbance of consciousness and a change in cognition that develop rapidly over a short period (DSM-IV-TR).

**Causes:**

- **Vascular:** Intercranial haemorrhage, Hypertensive encephalopathy
- **Infection:** Encephalitis, Meningitis
- **Neoplastic:** Space occupying lesions
- **Intoxication:** Chronic intoxication or withdrawal effect of sedative- hypnotic drugs
- **Traumatic:** Subdural and epidural hematoma, laceration, postoperative, heatstroke
- **Vitamin deficiency**: For example, thiamine
- **Endocrine and metabolic:** Diabetic, coma and stroke, Hepatic failure, Uraemia
- **Metals:** Heavy metals, lead, mercury and carbon monoxide
- **Anoxia:** Anaemia, Pulmonary or cardiac failure

**Clinical Features:**

- **Altered consciousness** ranging from hypervigilance to stupor or semi coma.
- **Extreme distractibility** with difficulty focusing attention.
- **Disorientation** to time and place.
- **Impaired reasoning** ability and goal-directed behaviour.
- **Disturbance in the sleep wake cycle**.
- **Emotional instability** as manifested by fear, anxiety, depression irritability, anger, euphoria, or apathy.
- **Misperceptions of the environment**, including illusions and hallucinations.
- **Automatic manifestations**, such as tachycardia, sweating, flushed face, dilated pupils, and elevated blood pressure.
- **Incoherent speech**.
- **Impairment of recent memory**.

**Diagnostic Findings**

Laboratory tests that may be helpful for diagnosis include the following:

- **Complete blood cell count with differential:** Helpful to diagnose infection and anaemia
- **Electrolytes**: To diagnose low or high levels.
- **Glucose:** To diagnose hypoglycaemia and hyperosmolar nonketotic states.
- **Renal and liver function tests:** To diagnose renal and liver failure.
- **Thyroid function studies:** To diagnose hypothyroidism.
- **Urine analysis:** Used to diagnose urinary tract infection.
- **Urine and blood drug screen.** Used to diagnose toxicological causes.
- **Thiamine and vitamin B12 levels.** Used to detect deficiency states of these vitamins.
- **Serum marker for delirium.** The calcium binding protein S-100 B could be a serum marker for delirium. Higher levels are seen in patients with delirium when compared to patients without delirium.

## Medical Management

When delirium is diagnosed or suspected, the underlying causes should be sought and treated.

- **Fluid and nutrition: Fluid** and nutrition should be given carefully because the patient may be unwilling or physically unable to maintain a balanced intake; for the patient suspected of having alcohol toxicity or alcohol withdrawal, therapy should include multivitamins, especially thiamine.
- **Reorientation techniques:** Reorientation techniques or memory cues such as a calendar, clicks, and family photos may be helpful.
- **Supportive therapy:** The environment should be stable, quiet, and well-lighted; sensory deficits should be corrected, if necessary, with eyeglasses or hearing aids; family members and staff should explain proceedings at every opportunity, reinforce orientation, and reassure the patient.

## Pharmacologic Management

Delirium that causes injury to the patient or others should be treated with medications.

- **Antipsychotic:** This class of drugs is the medication of choice in the treatment of psychotic symptoms of delirium.
- **Benzodiazepines:** Reserved for delirium resulting from seizures or withdrawal from alcohol or sedative hypnotics.
- **Vitamins.** Patients with alcoholism and patients with malnutrition are prone to thiamine and vitamin B12 deficiency, which can cause delirium.
- **Hypnotic, miscellaneous.** Agents in this class may be useful in the prevention and management of delirium (e.g. melatonin, ramelteon).

## Nursing Management

Nursing management for a patient with delirium include the following:

## Nursing Assessment

Nursing assessment should include:

- **Psychiatric interview.** The psychiatric interview must contain a description of the client's mental status with a thorough description of behaviour, flow of thought and speech, affect, thought processes and mental content, sensorium and intellectual resources, cognitive status, insight, and judgment.
- **Serial assessment:** Serial assessment of psychiatric status is necessary for determining fluctuating course and acute changes in mental status.
- **Assess level of anxiety.** Assess client's level of anxiety and behaviours that indicate the anxiety is increasing; recognizing these behaviours, nurse may be able to intervene before violence occurs.
- **Provide an appropriate environment.** Maintain a low level of stimuli in client's environment (low lighting, few people, simple decor, low noise level) because anxiety increases in a highly stimulating environment.
- **Promote patient's safety.** Remove all potentially dangerous objects from client's environment; in a disoriented, confused state, clients may use objects to harm self or others.
- **Ask assistance from others when needed.** Have sufficient staff available to execute a physical confrontation, if necessary; assistance may be required from others to provide for physical safety of client or primary nurse or both.

- **Stay calm and reassure patient.** Maintain a calm manner with the client; attempt to prevent frightening client unnecessarily; Provide continual reassurance and support.
- Interrupt periods of unreality and reorient; client safety is jeopardized during periods of disorientation; correcting misinterpretations of reality enhances client's feelings of self-worth and personal dignity.
- **Medicate or restrain patient as prescribed.** Use tranquilizing medications and soft restraints, as prescribed by physician, for protection of client and other during periods of elevated anxiety.
- **Observe suicide precautions.** Sit with client and provide one-to-one observation if assessed to be actively suicidal; client safety is a nursing priority, and one-to-one observation may be necessary to prevent a suicidal attempt.
- **Teach relaxation exercises** to intervene in times of increasing anxiety.

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