Editorial

Delirium – everybody's business

Andrew Teodorczuk

Recently, I was invited to facilitate a workshop on the role of Liaison Old Age Psychiatry and the care of patients with delirium in the North of England. As you may know the key to any workshop is to place the emphasis on participants doing the work usually by means of a well organised small group exercise (preferably which is action focussed and finishes early). Working together delegates from liaison psychiatry had to map out how to implement the 2010 English NICE guidelines.

What struck me as they tackled the task in groups was the scale of the issue they were dealing with. Not surprisingly a commissioner in the room raised the important question of who should be implementing the guidelines and whether Liaison Old Age Psychiatry should not leave this to the Geriatricians. This prompted a healthy bout of dialogue following which the consensus was that delirium is too big for any one specialty to take ownership of. Delirium must remain everyone's business.

With this in mind it is crucial that organisations such as the European Delirium Association, the largest body of experts in the field, must flourish and grow.

However, given the scale of the issue, it is also clear that the EDA alone will not succeed without greater engagement from others. Potentially across the member states, countries must take ownership of delirium by means of their own national Delirium Associations which can promote the EDAs work. By such a process greater engagement with those who are unable to attend or afford our meetings can occur.

To start such conversations and address this need we have initiated a new series capturing the field of Delirium from various countries. In the first of the "State of the Art” series Dr Cerejeira and colleagues describe the view from Portugal drawing attention to challenges ahead. They highlight the findings of a Liaison service and outline how education is implemented on the wards.

Continuing with the theme of everyone's business and the need to share good practice Dr Kreisel provides a brief synopsis of the key headlines from last year's EDA congress in Bielefeld. I do hope you will be able to join us for the next meeting in Leuven, Belgium. Details on how to register are included at the end of this edition of Annals. Knowing the organisers, I suspect it will be a rich and varied program with something for everyone to take away to improve their practice back home.

To widen the scope of our understanding further I am delighted that in this issue of Annals, Dr Paddick and colleagues describe three case studies of delirium from Africa. Case studies are an excellent source of learning and, though more anecdotal, are invaluable to clinical practice and oft forgotten in today's world of evidence based medicine.

Lastly, Dr Davis updates us on the wiki project he and colleagues are developing. He ends the fascinating article with a call for all to contribute and build our knowledge of the field together. I would urge you take up the wiki challenge and work collaboratively towards a greater understanding of delirium. In short delirium remains everybody's business everywhere.

Newcastle upon Tyne, England

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Delirium State of the Art Series: The view from Portugal

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Background

In line with global demographic changes, the population of people aged over 65 years has been rising in Portugal as a consequence of decreasing fertility together with lengthening life expectancy. From 1960 to 2011 the elderly population increased more than 1 million, from 708,570 subjects (8% of the total population) to 2,022,504 (19.1%) (INE, Censos 2011). This changing demography presents an important challenge to the Portuguese health care system since the number of people affected with chronic medical conditions and neurodegenerative diseases, such as Alzheimer's disease, will undoubtedly rise.

A perspective of the current situation

In a large Portuguese general hospital (Centro Hospitalar Universitário de Coimbra, CHUC) located in the central region of the country patients over 80 years-old represent 28% of all acute admissions in medical wards. Within the Portuguese National Health System Liaison Psychiatry services remain the most common model of care delivery to these patients when manifesting a co-morbid psychiatric condition such as depression, delirium or dementia. The Psychiatrist co-operates in a regular, integrated and unrequested fashion, with a multidisciplinary team, which includes consultation aspects, visits and discussion of ward cases and education programs for general staff to improve their basic psychiatric skills (UEMS, 2009).

In the last year, a new Liaison Psychiatry service to the acute medical wards was established in CHUC according to the model developed in Newcastle upon Tyne (Mukaetova-Ladinska 2009). Data collected so far (107 referred patients) shows that while delirium continues to be largely under-recognized, acute behavioral disturbances (e.g.: agitation, disruptive behavior) are a major concern for clinical staff. These symptoms become particularly relevant when they affect the ward environment and delay or complicate the necessary diagnostic and/or therapeutic procedures. Behavioral disturbances are the main reason (up to 70%) for referral to Liaison Psychiatry of patients admitted to acute medical wards in CHUC. Not surprisingly, a significant proportion of patients with those behavioral disorders have delirium.

Patients who are diagnosed with delirium by Liaison Psychiatry tend to be referred for behaviour disturbance (77%) including agitation, retardation, refusal to eat, aggression and lack of compliance with nursing care. Other common reasons for referral are cognitive impairment and disorientation. When reviewing the referral notes from our colleagues, a minority of patients (12%) was accurately identified as having “confusion” but none were described as presenting with disturbed consciousness or reduced of levels of attention, which represent the core symptoms of delirium. Clearly, hyperactive delirium is the most common subtype diagnosed by Liaison Psychiatry (61%) suggesting that hypoactive forms are largely missed by clinicians in medical wards (and thus not referred). Less than one third of patients were able to be assessed with a brief tool such as Mini-Mental State Examination (MMSE) due to lack of cooperation and/or disease severity. This supports previous studies suggesting that MMSE may be an inadequate instrument to use in acutely ill elderly patients (Yates 2009).

Recently the Portuguese medical and nursing schools have consistently incorporated the topic of delirium into undergraduate curricula. However, health care professionals are still not proficient to recognize delirium symptoms in hospital setting and, in general, other psychiatric disorders
are also missed. There is evidence that medical doctors are less skilled to assess psychiatric symptoms than physical symptoms and it has been argued that failure to develop solid communication skills with the patient contributes to this problem (Teodorczuk 2007). Although it is unclear to what extent interventional educational strategies for delirium are clinically significant (Teodorczuk 2010) the Liaison Psychiatry team has been actively involved in providing training to ward-based staff. More specifically, three major activities include: fostering a climate for learning in the wards, delivering an integrated learning solution and supporting transfer and maintenance of competences. Educational content is mainly delivered during bedside assessment of patients encouraging health professionals to actively construct, integrate and associate clinical information rather than being passive recipients of instructional content. For example, discussion of contrasting cases can be useful for helping healthcare staff notice and recognize subtle clinical features such as inattention or impaired consciousness. Additionally, several formal sessions have been organized to specifically address descriptions of effective and ineffective performance, common workplace errors, and strategies for achieving high standard practice.

**Future challenges**

There is a need to build a set of systematic epidemiological data about delirium prevalence and incidence in the different settings with in the Portuguese NHS. This information is crucial to define the scale of the problem and to implement innovative strategies for the future. In the next years, an important objective would be to implement a multicomponent intervention package delivered by a multidisciplinary team trained and competent in delirium prevention into routine care. It’s success depends on a close partnership between the key elements of the organizational structure providing healthcare to elderly subjects, including medical and nursing schools, healthcare professionals, liaison psychiatry teams and policy makers.

**References:**


Teodorczuk A, Taylor JP, Soares Cerejeira JM, Mukaetova-Ladinska EB. The need to improve the teaching of assessment of psychiatric symptoms at undergraduate level. Med Educ. 2007 Dec;41(12):1237-8


The Wikipedia challenge

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There's little doubt that Wikipedia is one of the most highly accessed sources of information, and this is no less true for patients and their relatives who have experienced delirium. The article entry for Delirium is accessed 40,000 times per month. This is likely to be vastly greater than the number of times our own research outputs are read! Being involved in editing Wikipedia articles is an opportunity to influence this body of information for the benefit of patients and the general public.

Wikipedia is an online encyclopaedia. Each article is the result of a number of collaborative contributions. Anyone can sign up to edit articles. This is fundamentally a democratic process, one sometimes criticised for favouring consensus over expertise. But it needn't be like that, and the main way to make the article better is to invite contributions from those with specialist knowledge of the field.

For a few months, I've been working with a few experienced Wikipedia editors to improve the article content. I've been helped by Wes Ely, Colm Cunningham, David Meagher and Andrew Hall. Each addition and edit invites review from the entire Wikipedia community. We've received lots of helpful suggestions and advice on how to stick to Wikipedia's style guide.

There is still lots more work to do, and the article would benefit from the wider expertise of the *Annals*’ readership.

So how to get started?

Firstly, go to the Wikipedia article and have a look again:


You may not have previously noticed, but there are tabs along the top. Just to the right of the main article tab is the talk page: http://en.wikipedia.org/wiki/Talk:Delirium. This is where editors can discuss queries. It also shows that this is a C-quality article (quality rating in ascending order: C, B, A, Good Article, Featured Article), but also that it is rated as high priority in the overall WikiMedicine Project (a group of interested and experienced editors).

To the right, are the tabs for editing, viewing history and statistics. Sign up and get editing. It takes a tiny bit of getting used to. To the new editor, it can be a bit overwhelming. There is seemingly a host of conventions and links to lots of long style manuals. But be bold! Start making a few small edits. Improve some of the references. Anything you want to suggest, but not happy to change directly – leave a comment on the ‘Talk’ page. The other editors on the medicine articles are genuinely supportive. Lastly, if you’re completely turned off the idea of getting stuck in, please send me any thoughts and edits, and I’d be pleased to add them.

The overall goal would be to get this article rated as a ‘Good Article’, or indeed ‘Featured Article’. This would be a great result of mutual benefit to the EDA and the WikiMedicine Project.

Finally, I’d like to suggest that using your expertise to improve articles of a clinical nature – that patients and their families will be reading – is actually a part of our obligation as clinicians and scientists. And if you get the bug for doing it in other areas of Wikipedia, your efforts will always be welcome. See you on the ‘Talk’ pages!

Little is known about either the presentation or the prevalence of delirium in the elderly in sub-Saharan Africa.

A number of previous studies have found differences in the clinical presentation of psychiatric disorders such as depression, psychosis and visual hallucinations across cultures [1-3]. To our knowledge there have been no studies investigating differences in the presentation of delirium.

Here we present a selection of case histories and descriptions of delirium from a community based dementia prevalence study which was carried out in rural Tanzania. Further details including methods have been published elsewhere [4].

The study was carried out in the Hai district, located on the slopes of Mount Kilimanjaro in Northern Tanzania. From a total population of over 160,000, almost 9000 people were recorded to be over the age of seventy with the three main tribes being Chagga, Pare and Maasi. The majority of this rural population work as subsistence farmers, although some families produce cash crops such as coffee.

Case history 1

This eighty year old woman was still working full time in agriculture. Cognitive screening revealed functioning in the mild cognitive impairment (MCI) range. There was no functional impairment and she went regularly to the market as well as community and church meetings. Her daughter in law explained that a few months previously she had been very unwell with what they thought must be malaria. She had become suddenly very excited and had been seeing tomatoes and cooking pots in the air and trying to take them and cook with them. She had been running around, talking to people who were not there and on a number of occasions she had tried to go running out of the house during the night whilst not wearing any clothes. The daughter and daughter in law had had to stay awake for the whole night to prevent her from running away and to try to calm her but she would not listen to them. They thought she had a fever so they bought medicine for malaria. When she did not get better they took her to a health centre where she was admitted and given intravenous fluids. The malaria test was negative, and the doctors did not find anything else wrong. They were not told the cause of her illness.

Within a week she had recovered. Over the past three years the same thing had happened on two more occasions. They had noticed that since the last time it happened her memory had not gone completely back to normal and that she was forgetting things that she would never have forgotten before, such as messages and names of people she did not know well, but that she was still able to work and to carry out her normal activities.

Case history 2

The patient and her family gave her age as 100. The history from the house girl was that until two months previously she was completely normal. She was walking with a stick and would direct them and supervise...
them in their work. She was a wise woman and could recount histories of the village. Over the past two months they had noticed the gradual onset of 'old age' and specifically that she was no longer able to understand and interpret others correctly. She had become easily angered and often frightened of them and frequently thought they were going to harm her. She was seeing people who were not there and shouted that these people are coming to kill her with sharp knives. Lately she appears tired and sleepy, not paying attention to the household. She forgets messages and that people have been to visit and greet her earlier in the day. Previously her memory was normal. She is not sleeping well at night, calling out to people who are not there. She says that she has been bewitched.

They had not sought medical advice or help, because they thought she was simply becoming old. Routine blood tests revealed undiagnosed diabetes and she was referred to the local hospital for further monitoring and treatment. She died a few weeks later.

Case history 3

This eighty seven year old woman was living with her extended family. Her daughter in law gave a clear history of a sudden onset of dementia following a stroke around one year previously.

They also described three or four episodes of 'confusion' lasting several days at a time. During the confusion she will not go to bed and is very angry with her family. She sees her dead brothers and sisters and takes food from the kitchen to give them. The family later find this food under the bed. During these times she will pass urine on the floor and on her clothes which she would never do normally. She resists them when they try to help her to dress and sees imaginary people who she calls out to, particularly at night. They cannot reason with her. When the confusion is over, she goes back to normal and can wash and dress herself and is continent. Her memory has never gone back to normal. In between these episodes she does not see people who are not there and allows the family to help her.

They had not sought medical help during these episodes, despite the distress and disruption caused to the family because they had not thought of these problems as being related to illness. They did take her to the village dispensary on other occasions, particularly if she complained of pain.

Discussion

It is recognised that in the developed world, the prevalence of delirium in the community is very low, because development of delirium is highly likely to lead to medical help being sought [5]. In these case histories, two families had not sought medical help at all. This was because they had not recognised the episode as being potentially due to illness.

In developed countries, delirium is recognised as a significant problem in elderly persons admitted to hospital and to be associated with both poor outcomes and mortality [6].

In contrast, data on this issue in sub-Saharan Africa is currently not available. To our knowledge only two small studies of psychiatric morbidity in hospitalised elderly from this region have been published [7,8]. Another study carried out in an adult outpatient population found that delirium presented much more commonly to psychiatry than would be expected in the developed world [9]. This problem is likely to be compounded by the fact that there are very few neurologists and even fewer geriatricians in sub-Saharan Africa [10,11]. Further studies of the presentation and causes of delirium in the elderly in sub-Saharan Africa are needed, in order to increase awareness of the problem and to improve detection rates and outcomes in these patients.
References:


Review of EDA Congress 2012 Bielefeld

Dr Stefan Kreisel, conference co-director, Bielefeld University

At the end of last year the EDA met for its 7th annual meeting at the Evangelical Krankenhaus Bielefeld (EvKB). The conference hosted presentations focused on basic sciences research, sharing the most recent data in the fields of delirium prevention, diagnosis, and treatment. Accompanying the main conference was a parallel German-language ‘Delirium Day’ which was open to the public.

Headline studies

Much anticipation awaited results of a large RCT drug prevention trial (n=435) targeting the sleep-wake cycle disturbance associated with delirium. Heady expectations soon sobered up as Prof Sophia de Rooij and Dr Annemarieke de Jonghe revealed the results from Amsterdam. Postoperative hip replacement patients treated with Melatonin at a dose of 3mg/ day had no significantly lower risk of developing delirium as compared to those treated with placebo.

A comprehensive study from Nottingham, UK led by Professor Rowan Harwood was also presented. The study focused on non-surgical patients over the age of 65 years with delirium at hospital admission. A total of 345 patients were randomised to care on a specialised ‘Delirium Ward’ or alternatively to standard ward setting care. Despite the delirium specific treatment strategy, Prof Rowan Harvey reported that no significant difference was demonstrated in either delirium duration, or in 90 day mortality. However there was a significant difference in patient and carer satisfaction that favoured the specialised ‘Delirium Ward’ care.
A call for consensus on delirium diagnosis

To have any hope of treatment, delirium must first be easily recognised as such by all physicians and distinguished early on from other related syndromes. To this end Prof Theodore Stern, psychiatrist at Harvard University, Boston, USA, advocated clear diagnostic strategies for physicians: “A systematic approach using neuropsychiatric screening tests to direct further diagnostic investigation. Each symptom of delirium identifies a particular brain dysfunction, which should identify investigations to be pursued. Delayed or missed diagnoses, trace back to lapses in the art of diagnosis”. Prof Karen Neufeld, of Baltimore, USA, and future President of the sister American Delirium Society, identified specific obstacles in this process. The practicality of making a diagnosis remains confused by the use of different criteria between the European (ICD-10) and American (DSM-IV) disease classifications. The absence of a diagnostic gold-standard, together with the use of multiple screening tools also act to make diagnostic clarity more demanding. Neufeld appealed to the EDA, as the largest assembly of delirium specialists for a consensus to determine this gold standard.

Differential diagnosis

The sheer breadth of differential diagnoses in delirium was a theme developed by Prof Christian Bien. Prof Bien is the director of the Mara Hospital Epilepsy centre here in Bielefeld. Bien presented several clinical cases of cerebral auto-immune disease with syndromal overlaps with delirium.

Prof Jörg Schulz, a Neurologist in Aachen, Germany elaborated on the sometimes subtle features distinguishing delirium from Parkinson’s disease, and Lewy Body Dementia. Differentiation between the three can be particularly onerous, noted Schulz, given that both Lewy Body and Parkinson’s are themselves risk factors for delirium, and so may play a role in the background of an acute illness.

Conclusion

With 250 registrations in total and 25 submitted oral presentations the conference once again was a great success. The next Congress is being held in Belgium in September 2013. We hope to see you there!

Editor’s Choice – recent publications

Antipsychotics: Yes? Maybe? Or No?

Valerie Page

Prophylaxis with antipsychotic medication reduces the risk of postoperative delirium in elderly patients: a meta-analysis.

Antipsychotic prophylaxis in surgical patients modestly decreases delirium incidence - but not duration - in high-incidence samples: A meta-analysis. (PMID:23351526) General Hospital Psychiatry. Gilmore ML and Wolfe MD on line first.

Not one but two recent meta-analyses have examined the use of prophylactic antipsychotics and reassuringly reviewed the same 5 studies totalling 1491 patients. One study of note which comparing enteral olanzapine and placebo prior to joint surgery showed a reduction in the incidence of delirium from 40.2% to 14.3% but the patients in the intervention group had a more severe delirium of longer duration. Both meta-analyses determined that perioperative use of prophylactic antipsychotics may effectively reduce the overall risk of postoperative delirium but Gilmore and Wolfe concluded that as the protective effect was modest, and given the potential adverse reactions there was insufficient evidence to support routine use.

This large cohort study looked at 77 759 US patients admitted to nursing homes for the first time for rehabilitation after hip fracture surgery. The Nursing Home Confusion Assessment Method was used to determine whether the residents had delirium symptoms on admission or not. Residents with no evidence of delirium symptomatology on admission who received antipsychotics had a greater likelihood of death before discharge, longer lengths of stay, less functional improvement and less likely to return to the community. In addition patients who had symptoms of delirium who were receiving antipsychotics did not appear to benefit with regard to clinical outcomes.

Hertfordshire, UK
The American Delirium Society (ADS) invites you to attend its 3rd Annual Meeting.

Learn from colleagues and contribute to scientific ideas regarding delirium etiology, state of the art clinical practice and ground breaking research presentations. Meet like-minded clinicians and scientists from many different disciplines and specialties; develop friendships and research partnerships. This is a great networking opportunity!

Guidelines for authors

Annals of Delirium Care is publication of the European Delirium Association which seeks to advance knowledge in the field of delirium. It is published three times a year (March, July, October). We especially welcome opinion pieces, reviews and research articles in the field.

Please send your ideas for contributions to the next Annals to Valerie.page@whht.nhs.uk or Andrew.Teodorczuk@ncl.ac.uk