PALCARE
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THE JIMMY S BILIMORIA FOUNDATION

PALLIATIVE CARE
GUIDELINES
FOR A HOME SETTING IN INDIA

DELIRIUM

INTRODUCTION

Delirium is a very common neuropsychiatric disorder with a multi-factorial aetiology, seen in patients with advanced illness. It is distressing to patients, families, and caregivers. It is characterised by disturbances in level of alertness, thinking, perception, cognition, psychomotor behaviour, mood and sleep-wake cycle. Based on presentation, delirium is divided into three subtypes - hypoactive, hyperactive, and mixed.

Terminal anguish is a combination of delirium and overwhelming anxiety in the last few days of life and is often irreversible.

The precipitating factors in the development of delirium in patients with advanced cancer are:

- Change of environment
- Unfamiliar excessive stimuli - too hot, too cold, wet bed, crumbs in bed, creases in sheets
- General deterioration
- Uncontrolled symptoms - pain, fatigue, anxiety, depression
- Metabolic disturbance - hypercalcemia, hyponatremia, hypernatremia, dehydration, hyperglycaemia, hypoglycaemia
- Organ failure - renal failure, liver failure, respiratory failure
- Medications - opioids, benzodiazepines, anticholinergic agents, steroids
- Infection - sepsis, pneumonia, urinary tract infection
- Neurological disorder - primary brain tumour, brain metastases, leptomeningeal disease
- Hypoxia
- Withdrawal - alcohol, benzodiazepines, nicotine, opioids
- Haematological - disseminated intravascular coagulation, anaemia

ASSESSMENT

- **Assessment** must determine the underlying cause of delirium, effectiveness of treatment and impact on quality of life for the patient and their family (***refer to the Guideline - Symptom Assessment***)
- **Accurate history** from caregiver/family member is necessary
- **Consider using screening tool:** mini-mental state examination (MSE) for cognitive impairment

- **Symptoms and signs**
  - Clouding of consciousness (reduced awareness of environment)
  - Impaired attention
  - Impaired memory, especially recent memory
  - Impaired abstract thinking and comprehension
  - Disorientation in time, place, or person
  - Perceptual distortions - illusions and hallucinations, usually visual or tactile
  - Transient delusions, usually paranoid
  - Psychomotor disturbance - agitation or underactivity
  - Disturbed sleep-wake cycle, nightmares
  - Emotional disturbance - depression, anxiety, fear, irritability, euphoria, apathy, perplexity
  - It is important to differentiate this from depression and dementia
- **Investigations (If appropriate)**
  - Check full blood count and biochemistry, including calcium
  - Check for infection (urinary tract infection)

MANAGEMENT

- **Correct the correctable**
  - Treat the underlying cause
  - If nicotine withdrawal, use TD nicotine patches
  - If alcohol or benzodiazepine withdrawal, then consider benzodiazepine
  - Pain management
  - Review medication likely to be the cause of delirium and prescribe alternative
- **Non-pharmacological measures**
  - Explain to patient and family what is happening, why and what is being done
  - Frequent orientation and avoid confrontation
  - Respond to patient's comments
  - Treat patient with courtesy and respect
  - Avoid use of physical restraints (use only if absolutely essential)
  - Ensure bowel and bladder function
  - Use of visual and hearing aids
  - Environmental modifications (e.g. quiet, well-lit room with familiar objects, a visible clock or calendar) to enhance orientation
  - Avoid frequent staff changes
  - Allay fear and suspicion

- **Pharmacological management**
  - **Medication used for mild restlessness**
    - Haloperidol 0.5 - 1.5mg PO tid; the parenteral dose should be 50% of the oral dose
    - Alternatives
      - Risperidone 0.5 - 1mg PO bd
      - Olanzapine 2.5 - 15mg PO OD
      - Quetiapine 50 - 100mg PO bd
    - Lorazepam 1 - 2mg S/C should be used as an adjunct only on a prn basis only until the neuroleptic provides control
  - **Medication used for delirium and agitation in terminal phase**
    - **Restless and confused but cooperative**
      - Haloperidol 1.5-5mg PO or S/C q4h - q8h
    - **Delirium with Paranoia, Confusion and/or Aggression**
      - Haloperidol 5-10mg S/C or IV q30 - q60 minutes until relief; then maintenance dose is 50% of amount to achieve control (usually between 1.5-20mg/24 hours divided into one to three doses)

        OR
      - Methotrimeprazine 10-50mg S/C q30 minutes until relief; then 10 - 50mg PO, S/L or S/C q4h - q8h

        OR
      - Chlorpromazine 50 - 100mg IM, PR or IV q1h until relief; then 12.5 - 50mg PO or IV q4h - q12h
  - **Consider palliative sedation when all other measures have failed (*refer to the Guideline - Severe Uncontrolled Distress*)**

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