

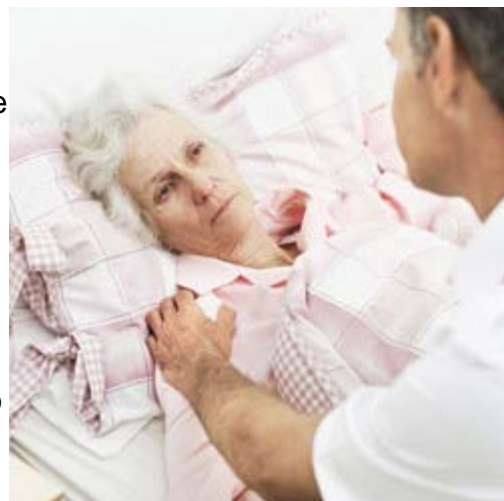
The dilemma of delirium in older patients

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Researchers look for new answers to age-old problem

Ill and hospitalized older people sometimes experience episodes of delirium, a state of confusion and disorientation. For centuries considered a transient and reversible condition, delirium in older people is still viewed by many to be a normal consequence of surgery, chronic disease, or infections.

There is mounting evidence, however, that delirium may be associated with increased risk for dementia and may contribute to morbidity and death. One recent study found that in a group of 553 people age 85 and older, those with a history of delirium had an eight-fold increase in risk for developing dementia ([Davis et al., 2012](#)). The researchers also found that among the participants with dementia, delirium was associated with an acceleration of dementia severity, loss of independent functioning, and higher mortality. These findings showed that delirium is a strong risk factor for dementia and cognitive decline in the oldest old.



Growing momentum, awareness

At NIA and throughout the geriatric research community, momentum is building to better understand the mechanisms involved in delirium and to improve ways to recognize and treat the condition.

Currently, NIA supports several [clinical trials](#) focused on finding effective drugs and protocols to prevent or reduce the impact of delirium in hospitalized older people. The goal is to identify a variety of interventions that reduce delirium for patients in intensive care, including the testing of supplements, pain medications, and sedatives that may alleviate delirium in pre- and post-operative patients.

“The research and medical communities are becoming more aware and interested in the impact delirium may have on the long-term cognitive health of older patients,” said Dr. Molly Wagster, Chief of NIA’s Behavioral and Systems Neuroscience Branch. “At this stage, unfortunately, there are more questions than answers. In order to treat or prevent delirium, it will be important to determine why some older people are more susceptible to developing it during hospital stays or as a result of trauma or illness.”

In addition to supporting the clinical trials, NIA, in collaboration with the [American Geriatrics Society](#) (AGS), is sponsoring a conference on delirium in early 2014 through a cooperative grant mechanism. As part of the AGS Bedside-to-Bench conference series, the meeting will cover a wide array of delirium-related research topics, including biomarkers, genetic risk factors, neuroimaging, inflammation, brain injuries, drug and nondrug interventions, and animal models. Recommendations from the meeting will inform research on this topic for years to come.

These activities join efforts already underway of the [American Delirium Society](#) (ADS), a group formed by researchers and clinicians seeking better understanding of the science of delirium and its prevention,

treatment, and long-term consequences. The group hosts an annual conference that draws a mix of clinicians and scientists from many different disciplines and specialties.

Attitudes about delirium evolving

Dr. Joseph Flaherty of the Division of Geriatrics at Saint Louis University, a leading member of ADS, says that attitudes about delirium are slowly evolving among medical practitioners.

“As a medical student 20 years ago, I was taught delirium was completely reversible. That’s simply not the case for many older patients,” he said. “Over the past 15 years, interest has grown in identifying ways not only to reverse the condition, but to prevent it from occurring in the first place.”

He applauds NIA funding of delirium drug trials, but also suggests that changes in nursing and hospital protocols today could help prevent the onset or reduce the severity of delirium.

“Changing the hospital environment and culture to match what the older patient with delirium or at risk for delirium needs is critical,” Dr. Flaherty said.

Examples of such changes include allowing hospitalized older people to sleep undisturbed between 10 p.m. and 6 a.m. so that their normal sleep cycle is less disrupted, not using physical restraints, and giving staff concrete nonpharmacologic methods to deal with agitation that may occur with delirium ([Flaherty et al., 2011](#)).

“There are very promising, nonpharmacological methods being tested that may enable hospitals and nursing facilities to prevent, treat, and manage delirium,” he said. “For example, the new standard in ICUs is to get patients up and out of their beds within 1 to 2 days, even if they are connected to a ventilator. This reduces the number of days with delirium and time spent in intensive care.”

Dr. Flaherty said these new methods may also improve the odds of regaining normal cognitive as well as physical function ([Schweickert et al., 2009](#)).

References:

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