CORRESPONDENCE

Acute Confusional States in the Elderly—Diagnosis and Treatment

by Prof. Dr. med. Dipl. Pall. Med. Stefan Lorenzl, Prof. Dr. med. Ingo Füsgen,
Prof. Dr. med. Soheyl Noachtar in volume 21/2012

Eliminate Noxious Agents Acting as Triggers

The authors deserve thanks for their profound exploration of this topic, which is so important in routine clinical practice (1). (Onsetting) dementia is a predisposing factor, and delirium is common in dementia (ICD F05.1). Often, undetected dementia is unmasked only by delirium. Identifying such patients in advance by using suitable screening instruments lowers the frequency of delirium drastically (2). It is important to mention that in patients with known dementia and plausible trigger factors, the diagnostic efforts should be kept in proportion: electroencephalogram and cerebrospinal fluid (CSF) analysis are not among the basic diagnostic tools.

With regard to treatment it should be emphasized that the elimination of noxious substances acting as triggers is the first priority; these include numerous medications—and especially polypharmacy. The importance of environmental therapeutic factors (alleviating patients' fears/anxiety, enable reorientation) should not be underestimated, since a lack of orientation and fear/anxiety lead to further escalation of the pathophysiological cascade of delirium via corresponding psychophysiological mechanisms (3). Long acting benzodiazepines should not be used to treat delirium in elderly patients because of the risk of gradual intoxication, with adverse effects including respiratory depression.

Delirium usually does not last longer than hours to several days, but in some cases it may persists for weeks, including postoperatively. Durations of six months have been observed (4). The reversible character of the symptoms is then often overlooked and hospitals admit patients prematurely to nursing homes.

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Echocardiography Is not a Basic Diagnostic Test

As a specialist in internal medicine/cardiologist, I found it odd that echocardiography is listed as the second item in the list of basic diagnostic tools,

I did not gain clarity about the indication even after reading the entire article. In my opinion, the article does not provide a clinically relevant basis for the diagnostic relevance of echocardiography, anywhere.

For me, as the doctor doing the examinations, this would have been of particular interest since I have already been able to work on requests for transthoracic echocardiography to confirm the presence, or otherwise, of “delirium” in a small department for internal medicine in a specialist psychiatric hospital.

In order to diagnose cardiogenic shock, more sensitive parameters exist, such as blood pressure and pulse rate. Not every infection masks endocarditis. Cardiac decompensation may be present even if the systolic pump function seems normal in the thoracic echocardiography.

How, then, does this diagnostic measure—which means that a patient is moved by strangers from his/her familiar room into an unfamiliar new environment and to a unfamiliar new doctor—ultimately help me with my therapeutic efforts?

Does this not contradict another recommendation in *Box 6*, namely, that of creating a safe, quiet environment?

In my opinion, the benefits are not in proportion to the harmful effect. Of course it may be said that transthoracic echocardiography is a bedside investigation (such as the EEG), but is this at all realistic?

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In Reply:

We agree that echocardiography, electroencephalogram, and CSF analysis are not indispensable in the basic diagnostic repertoire. Our explanations of basic diagnostic tools were comprehensive and wide-ranging, as this is how they are conducted in large hospitals.

Echocardiography attempts to detect early in the process the onset of heart failure or infectious cardiac disorders. Heart failure in elderly patients is clinically often difficult to identify in the early stages and can decompensate rapidly in acute medical conditions, including delirium. It is well known that neurological and psychiatric complications, including psychosis and delirium, develop in 20–30% of patients with infectious endocarditis (1). Blood culture results are negative in 10–20% of cases of endocarditis (2). Especially in patients with renal failure, immunocompromised patients, and patients who had preceding antibiotic treatment, echocardiography is a very useful diagnostic examination when trying to identify infectious endocarditis (3).

The EEG is an indispensable diagnostic tool in differentiating non-convulsive epileptic states from confusional states with a different pathogenesis.

Regarding treatment with long acting benzodiazepines we agree with Wolter. Our experiences with “long acting” benzodiazepines relate to midazolam, which we have used with good results especially in confusional

states in the palliative phase as a continuous subcutaneous (s.c.) infusion. The indication should be strictly defined and the dosage and application method (for example, s.c. continuously over 24 hours) carefully selected. The advice that benzodiazepines can result in further escalation of the confusional state is important. This applies especially to long acting benzodiazepines in elderly patients. We also found the advice about the duration of confusional states important, which because of their fluctuation cannot be categorized correctly and therefore result in early discharge.

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Conflict of interest statement

All authors declare that no conflict of interest exists.