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Response

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We agree with the comments by Dr. Regal (1) that taking into consideration the underlying clinical condition and the speed of delirium resolution will provide opportunities for practitioners to appreciate the full spectrum of acute brain dysfunction. At present, we do not have a consistent etio-pathologic definition of intensive care unit (ICU) delirium; although there is available evidence that delirium predisposed by different contributors portends different prognoses to patients (2). As shown by Patel et al, patients whose delirium resolve with a sedation holiday classified as rapidly reversible, sedation-related delirium had fewer ventilator days ($P<0.001$), ICU days ($p=0.001$), and hospital days ($p<0.001$), compared to the patients with persistent delirium (2). This is an area of active research and further work will shed light on how to better classify and characterize these patients. We believe though that use of the Confusion Assessment Method for the ICU-7 (CAM-ICU-7) Delirium Severity Scale (3) will help in these efforts. CAM-ICU-7 could provide an easy reference for busy clinicians to clinically determine if the delirium severity is on an upward or downward trajectory. Consistent use of the CAM-ICU-7 could identify both the resolution as well as the fluctuation without any additional time allocation. Additionally, an easily utilizable ICU delirium severity scale could help the research community to further answer the excellent points raised by Dr. Regal (1).

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