

Delirium Management Still Elusive, Studies Needed

BY DOUG BRUNK
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LONG BEACH, CALIF. — So little is known about effective interventions for delirium that efforts to help elderly patients with the condition leave many providers, well, delirious.

The goal of treating delirium is not just to control agitation or hallucinations, but to reverse the delirium and thereby mitigate associated morbidity and mortality risks, Dr. Jay S. Luxenberg said at the annual meeting of the California Association of Long Term Care Medicine.

"The modern concepts of delirium emphasize that delirium can be a persistent issue for a given patient, persisting months and even years," said Dr. Luxenberg, an internist and geriatrician who is medical director of the Jewish Home in San Francisco. "It may actually reflect a current decline in cognitive functions."

Another emerging concept about delirium is that it markedly and independently affects patient outcomes such as length of stay, functional decline, and loss of independent living.

"What we need to be thinking of is baseline vulnerability to delirium: what pushes people over the edge," said Dr. Luxenberg, also of the University of California, San Francisco. "Ultimately, the precipitating factor is just that: the precipitating factor. Of course if they have a urinary tract infection, we're going to treat it. If they have bronchitis, we're going to treat it."

The exact incidence of delirium among the elderly is not known, but Dr. Luxenberg said that it is surely higher than the national average of 2% reported by Medicare for the period of July 1, 2006, through Dec. 31, 2006. "It isn't being identified as clearly as it should be," he asserted.

He recommended being specific about delirium symptoms of risk factors during admission assessments (see sidebar). "On your problem list, identify things explicitly because the people who do the [Minimum Data Set] look for written data from the doctor," he said. "Anytime a patient is on a lot of medications we should list

polypharmacy as one of their problems, even if they need every one of those drugs. Similarly, if the person has delirium, we should write it, not imply it."

In a study of 2,158 patients with an average age of 84, admitted to a skilled nursing facility from a hospital, 16% had delirium as defined by the Confusion Assessment Method (J. Gerontol. A Biol. Sci. Med. Sci. 2003;58:M441-5). In addition, about 13% of patients had two or more symptoms of delirium and about 40% had one symptom of delirium.

Unresolved, delirium can have significant impact on mortality. One study of 393 postacute care patients (with an average age of 84 years) found that functional recovery differed significantly by delirium resolution status (J. Gerontol. A Biol. Sci. Med. Sci. 2006;61:204-8). Specifically, patients who resolved their delirium within 2 weeks without recurrence regained 100% of their prehospital functional level, while those who did not retained less than 50% of their prehospital functional level.

In a more recent study, researchers used the Memorial Delirium Assessment Scale to assess psychomotor activity in 457 newly admitted delirious postacute care patients (J. Gerontol. A Biol. Sci. Med. Sci. 2007;62:174-9). The patients were classified as hyperactive, hypoactive, mixed, or normal.

Hypoactive patients were 1.6 times more likely to die during 1 year of follow-up compared with patients who had normal psychomotor activity, a difference that was statistically significant. Patients with the hyperactive and mixed subtypes had an increased risk of dying during 1 year of follow-up compared with patients who had normal psychomotor activity, but the elevations were not statistically significant.

The current data on treatment options for delirium "makes you yearn for more data and better studies," he said.



A Cochrane review that Dr. Luxenberg helped assemble on the use of antipsychotics for delirium found only three studies suitable for inclusion (Cochrane Database of Systematic Reviews 2007, Issue 2. Art. No.: CD005594. DOI:10.1002/14651858.CD005594.pub2.) Meta-analysis was only possible in comparing risperidone vs. haloperidol and olanzapine vs. haloperidol. The results showed no significant difference in overall effect on delirium with olanzapine or risperidone compared with haloperidol.

Data on the use of cholinesterase inhibitors and benzodiazepines for delirium are even more sparse.

One controlled study of haloperidol as a delirium prophylaxis in hip surgery patients found that while there was no effect on the postoperative incidence of acute confusion, patients in the haloperidol arm had earlier improvement of delirium scores and had less severe delirium compared with patients who did not take the drug. The average age of study participants was 79 years (J. Am. Geriatr. Soc. 2005;53:1658-66).

"Somebody should do this study again," Dr. Luxenberg said. "This is potentially interesting."

Until more is known about medical interventions for delirium, other approaches are worthy of consideration, including the use of bright or blue light for circadian rhythm disturbances, complementary and alternative medicine, and minimizing the need for restraints by using clysis and by using intramuscular injections instead of intravenous injections, he said.

"Deemphasize the idea that you have to search for an underlying cause of delirium, such as [ordering] a CT scan to look for intra-abdominal abscesses," he said. "Looking for the common things—the drugs, the [urinary tract infections]—suffices. If the patients aren't coughing, they're not short of breath, and their oxygen saturation is fine, they probably don't need a chest CT to look for occult pneumonia as the cause of their delirium." ■

'Deemphasize the idea that you have to search for an underlying cause of delirium.' Look at drugs, UTIs instead.

DR. LUXENBERG

Insomnia Treatment in the Elderly Is Complex, Unpredictable

BY HEIDI SPLETE
Senior Writer

MINNEAPOLIS — Metabolic changes and comorbid conditions are just a few of the challenges involved in treating insomnia in older adults.

"The predictability of your giving drug X to patient A and knowing what is going to happen goes way

down. That's the bottom line," said Dr. Daniel Buysse, a professor of psychiatry and the director of the Clinical Neuroscience Research Center at the University of Pittsburgh.



The physiologic changes that occur with aging affect how the body absorbs medication, Dr. Buysse said at the annual meeting of the Associated Professional Sleep Societies.

"As we get older, our lean body mass decreases and our adipose tissue increases," he noted. Because the drugs used to treat insomnia are lipid soluble, older adults who have a greater proportion of adipose tissue will store the drug longer before

processing it through the body, Dr. Buysse explained. Consequently, older patients may have more residual sleepiness the next day after taking a sleep medication the previous night, and their dosages may need adjustment.

Hypnotics have shown effectiveness in treating insomnia in adults, but be aware that the measured blood concentrations of

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DR. BUYSSE

drugs are much more variable in an older population, Dr. Buysse said. In addition, some data have shown that hypnotics are associated with cognitive and psychomotor problems in older patients.

Antidepressants such as trazodone may be helpful for some patients; but be aware of the risks of dizziness, which could lead to falls, and the risk of oversedation because of older adults' slower metabolisms. Choosing insomnia medications for older adults is tricky, said Dr. Alon Avidan, a neurologist at the University of California, Los Angeles. Drugs have their risks, but untreated insomnia can be just as risky, because it has been linked to an increased

risk of falls in older adults. Elderly people who wake up at night are likely to get out of bed, which means that they are at greater risk for falls than older adults who are able to sleep longer.

In fact, hypnotics may be protective in preventing falls in older adults with insomnia, Dr. Avidan said, based on data from his study of more than 34,000 nursing home residents with an average age of 84 years (J. Am. Geriatr. Soc. 2005;53:955-62).

The patients with untreated insomnia were 30% more likely to fall, compared with those who were treated with hypnotics. But treating insomnia had no measurable effect on the patients' risk for hip fractures, Dr. Avidan noted.

Dr. Buysse shared his top clinical considerations when choosing drug therapies for elderly patients with insomnia.

First, keep expectations realistic, he advised. "The fact that older adults have comorbidities may limit how well we can do with our treatments," he noted. Comorbid health conditions may affect how older adults feel during the day regardless of whether they have slept well.

Second, remind patients that insomnia medication is not a general anesthesia. "Some older adults look at sleep as a behavioral alternative when they run out of

things to do," Dr. Buysse said. "Some patients take a pill at 8 p.m. and they think they will be out for the night."

In addition, remember that no evidence-based treatment guidelines exist to direct treatment of insomnia in older adults.

"We have not the least idea how to match a particular treatment to a patient, and we don't really know what constitutes a clinically significant response," Dr. Buysse said.

Findings from a recent meta-analysis suggest that many of the drugs currently available for treating insomnia—including the nonbenzodiazepine hypnotics zolpidem and zaleplon, some benzodiazepines, and the antidepressant drug trazodone—have not shown consistent effectiveness in improving sleep in older adults (Ann. Clin. Psychiatry 2006;18:49-56).

Dr. Buysse recommended starting with a benzodiazepine receptor agonist, and then switching to a sedating antidepressant if the benzodiazepine doesn't help.

"When people still don't improve, you could start moving to other methods such as behavioral therapy," he said.

More research is needed to understand how to combine drug therapy with behavior therapy to treat insomnia in older adults, he added. ■