Dementia Network Algoma

Connecting minds

Dementia care newsletter

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Acute Agitation

It's Monday morning and Mrs. A's daughter is in a panic. Her 82 year old mother was acting "weird" over the weekend. She was speaking nonsense, paranoid and hallucinating, called in distress in the middle of the night stating that strangers were in her bedroom and that she has locked herself in the bathroom. She was agitated and not easily reassured. Mrs. A is usually a pleasant woman with mild dementia who lives independently in her apartment.

What would be your next step? **New onset of behavioural problems in dementia is delirium until proven otherwise.** Delirium should be considered a medical emergency. The diagnosis is too often missed although it is common in the elderly, often superimposed on dementia, and has a high mortality rate. Risk factors to consider are age, frailty, multiple chronic disease, dementia and multiple drugs. The hallmark of delirium is the inability to sustain attention, for example, patient having difficulties following a conversation. The diagnosis can be made by a physician using the Confusion Assessment Method (CAM) which has a sensitivity of 94-100% and specificity of 90-95%.

Confusion Assessment Method
1) Sudden onset and fluctuating course
2) Inattention AND
3) Disorganized thinking OR
4) Altered level of consciousness

Delirium= 1,2 AND either 3 OR 4 Inouye S. Ann Intern Med 1990; 113:941

Next it is necessary to find the cause of delirium as this is treatable. Most common causes of delirium are: "drugs, drugs, drugs, infection, metabolic and system failure". In the elderly there are often multiple underlying causes rather than one single cause. All drugs can cause delirium, worse are those with anticholingergic effects. The physician doing the investigation must ask about alcohol use, over-the-counter, herbal and prescription medications, new prescriptions or changes in dosing. A full physical examination needs to be conducted. Rule out infection such as urinary tract or pulmonary. Constipation and urinary retention can also be a culprit as also dehydration, poor nutrition and sleep deprivation.

Management should first address immediate safety needs, then identify and treat underlying causes(s). Non-pharmacological management includes providing supportive measures such as ensuring proper fluids and nutrition intake, providing familiar faces for reassurance (family) and orientation (calendar, clock), correcting sensory impairments (lights on), keeping a low level of stimulation and avoiding restraints. Pharmacological management is at best avoided and should only be a last resort solution to control symptoms.

Mrs. A is found to be acutely confused and delirious. Her urinalysis suggests an urinary tract infection and the blood work revealed signs of mild dehydration. An antibiotic is prescribed. Her daughter is agreeable to care for her mother for the next few days until the delirium resolves, ensuring that she would hydrate and feed herself adequately. In reviewing her list of medications the physician decides to stop her Detrol LA as this is an anticholinergic agent.

In summary, delirium should be highly suspected as the cause of any behavioural changes in the elderly. The CAM is a useful tool to make the diagnosis. Safety is to be addressed immediately. Underlying causes(s) are identified and treated promptly. Non-pharmacological management provides supportive measures while pharmacological management should be used only if absolutely necessary to control symptoms of agitation, aggression or psychosis.

Resource: Adapted from Dementia Newsletter for Physicians, Champlain Dementia Network, vol. 6 No. 3, Summer 2007
Dr. Louise Carrier, MD, FRCP C, Medical Director, Geriatric Psychiatric Community Services of Ottawa

Delirium—Signs and Symptoms	If delirium is suspected always:
Acute sudden onset is typical; although may also be less acute	Act immediately to correct the underlying causative medical problem. Remember, the cause is often due to more than one reason.
Fluctuating symptoms that can change throughout the day or hour	Ensure hydration and nutrition are adequate.
Disturbance in sleep-wake pattern, e.g. awake at night or sleepy during the day	Decrease environmental noise and change.
Fluctuations in activity, e.g. drowsy to agitated	Optimize hearing and vision.
Decreased attention	Keep in familiar surroundings.
Changes in cognition: Memory loss Disorientation Language disturbance Perceptual disturbance Hallucinations, i.e. seeing, hearing things that are not present Delusions, i.e. false fixed ideas/beliefs Misinterpretations, i.e. of what someone says, does or of something in the environment	Provide a consistent carer/family person who the person knows or recognizes. Maintain a well lit room. Use orientation cues such as a clock, calendar. These do make a difference.
Evidence from a physical exam or laboratory finding of medical condition that is causing the symptoms.	*Source: U-First Resource Guide and Workbook October 2005*

UPCOMING EVENTS

Alzheimer Society
SAULT STE. MARIE & ALGOMA DISTRICT

Alzheimer Education Conference 2008
COMMUNICATION & RELATIONSHIPS IN DEMENTIA CARE
Friday March 28, 2008, 8:30am-4:00pm
Algoma's Water Tower Inn

Keynote Address: Enhancing Communication to Preserve Personhood Among Individuals with Dementia, **Dr. J.B. Orange**

For more information or to register call the Alzheimer Society at 942-2195 or 1-877-396-7888

INVISIBLE **IMPAIRMENTS** OF ACQUIRED BRAIN INJURY
"SURMOUNTING THE OBSTACLES"

Keynote Speaker: Terry Evanshen, member of the Canadian Football League Hall of Fame and Survivor of an acquired brain injury

This full day session has been rescheduled from November 30 to January 2008.
For complete details contact the Brain Injury Association at 253-8876 or e-mail fandjhalford@yahoo.ca

RESOURCES

www.piecescanada.com P.I.E.C.E.S
www.u-first.ca U-First
www.alzheimer.ca Alzheimer Canada
www.viha.ca/ppo/learning/delirium/tools.htm Vancouver Island Health Authority

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To ensure that this newsletter is an effective source of information for you, your feedback is important to us. Please visit our website **www.dementiaalgoma.org** and fill out the evaluation.