To the Editor:

In their article recently published in the Journal, Kiely and colleagues (1) showed that the three psychomotor activities (hypoactive, hyperactive, or mixed) of delirium had an elevated 1-year risk of death in comparison with a normal psychomotor group, with the hypoactive group having the highest mortality risk. We want to contribute to this topic with our own data, referring to a population of 1864 patients (aged 65 years or older) consecutively discharged from our Rehabilitation and Aged Care Unit (RACU) between January 1, 2003, and January 31, 2006, and followed at 12 months. The diagnosis of delirium was made by two experienced geriatricians (G.B. and S.S.) using the Confusion Assessment Method (2), and the level of agitation/sedation was assessed by nursing staff three times daily using the Richmond Agitation and Sedation scale (RASS) (3). Delirium was categorized as hyperactive, hypoactive, and mixed type according to clinical judgment and RASS score. Delirium was detected in 229 (12.3%) individuals. Of these, 103 (45.0%) developed hypoactive delirium, 45 (19.7%) hyperactive delirium, and 81 (35.4%) mixed delirium. Patients in the three groups were similar concerning clinical characteristics, except for the albumin serum levels, which were lowest in the hypoactive group (2.8 ± 0.4 gr/dl vs 2.9 ± 0.5 gr/dl in the mixed and 3.0 ± 0.4 gr/dl in the hyperactive groups, p = .03 on Bonferroni post hoc analysis). Although not significant, the individuals with hypoactive delirium had also a lower Body Mass Index (BMI) score (BMI = 22.6 ± 4.5 in the hypoactive group, 22.9 ± 4.5 in the mixed group, 23.3 ± 4.3 in the hyperactive group; p = .72) and greater comorbidity (Charlson Index = 3.5 ± 2.1 in the hypoactive group, 3.4 ± 2.0 in the mixed group, 2.8 ± 1.8 in the hyperactive group; p = .14) in comparison to those with mixed and hyperactive subtypes. Figure 1 shows the Kaplan-Meier survival curves for the three delirium subtypes and the no-delirium group. The individuals with hypoactive delirium had the highest mortality rate, followed by the mixed group, then the hyperactive group, in decreasing order. The Cox proportional hazard analysis, after adjustment for covariates and confounders (age, gender, Charlson Index, albumin serum levels and preadmission Barthel Index score), revealed that the hypoactive group was 1.71 (95% confidence interval [CI], 1.07–2.75) times more likely to die during the 1-year follow-up relative to the individuals without delirium.

Our data are in line with the findings of Kiely and colleagues. We found that all psychomotor subtypes had a higher risk of mortality in comparison with individuals without delirium, and that those with hypoactive delirium were at the highest risk. The possible explanations for the differences in the rate of 1-year global mortality (22.3% in our study vs 41.6% in the study of Kiely and colleagues) include the differences among settings (post-acute facilities vs RACU) and the availability at discharge of network services for older people (i.e., home care, diurnal care for demented persons, and so forth), which are widespread in our area’s healthcare system. Moreover, in our patients with delirium, we adopted by default a plan of specific rehabilitation with the goal of reducing loss in functional status and improving walking ability (4).
References


