... the stab of wonder that accompanies the precise moment when, gazing at a tangle of twigs and leaves, one suddenly realizes that what had seemed a natural component of that tangle is a marvelously disguised insect or bird.

—V. Nabokov, *Speak Memory*

SHE had gone to bed well, albeit a bit threadbare cognitively, but she awakened wild-eyed, uncomfortable, jittery, and imprecise. Every hospital beep, bang, and shout was instantly distracting. Skidding from topic to topic she repeatedly declared to her unresisting audience an invincible fixity of purpose, only to be then unable to find her purpose. She was distraught that her mother was trapped inside the IV pump.

Unable to know her experience, we tried to name the phenomenology. Acute confusional state? Change in mental status (affectionately, “Delta MS”)? Acute organic brain syndrome? Encephalopathy? Her thinking was like farming when the plow just won’t stay in the furrow; “delirium.” We started the work-up.

Unwittingly, we took up The Mind–Body Problem and the Question of Consciousness, avocation of philosophers for millennia, now gradually morphing into research questions for hard scientists. Certain brain substrates are needed for the mind to function; sickness and toxins can cause malfunction. Religious experiences are brought on by psilocybin mushrooms in carefully controlled conditions (1). Psychiatrists and neurologists move toward each other. For clinicians, neither philosophers nor hard scientists, an elderly patient whose mind suddenly starts to misbehave seriously presents a perplexing menace. We take a very reductionist approach.

The normally functioning mind/brain is a wonder. Beneath consciousness we are constantly filtering, making countless assumptions every instant, effortlessly winnowing signal from noise (Nabokov knew), then making decisions and acting on them. What happened to this patient? The ceaseless progression of perceptions that was her consciousness (or is it “that was perceived by her consciousness”?) had stopped making sense.

Nomenclature, phenomenology, and pathophysiology are overlapping and heterogeneous. No gold standard diagnostic test is available. No blood test or scan can make the diagnosis of delirium. You have to go and see the patient, examine his or her mind. This clinical reductionism is useful, but primitive. At our level of understanding, a person who becomes fearful, restless, and confused when familiar cues are withdrawn, such as at sundown at her daughter’s house, has a brain that is not “doing” the same thing as the brain of a patient with low serum sodium or accumulated neurotoxins who is also diagnosed as delirious. Is it then reasonable to treat these, and patients with urinary tract infections or alcohol withdrawal, similarly?

We investigated the usual suspects, and they were innocent, save one. Drugs. In the night, she had received two dopamine blockers for nausea—compazine and metoclopramide—prescribed by rote for “symptomatic relief.” These were withheld and, mercifully, she was back to baseline 8 hours later.

Had she not recovered, how could we have managed? Based on a single trial, in which 30 patients were randomized into three arms (2), the standard drug recommendation is haloperidol, a dopamine blocker. Other dopamine blockers hold the same promise. With the heterogeneity of causes and phenomenology, the treatment is genuinely empiric here, as much as anywhere in medicine. As Plutarch noted, “Geographers crowd into the edges of their maps parts of
the world about which they know little, and add notes in the margin to the effect that nothing lies beyond this.”

*Note
Please see the Editors’ Note in the March 2006 issue of the Journal (p. 259) for a description of the article type “Chili Pepper.”

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