MANAGEMENT OF DELIRIUM IN THE ELDERLY

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Introduction: Delirium is common, has serious consequences, but is under-recognised & poorly managed. Rehabilitative management & reality orientation have been suggested to improve outcome. We aimed to establish current recognition and management of delirium.

Methods: 65+ admissions to medical and elderly care wards in 5 hospitals screened for delirium using DSM IV criteria. Data on the process and outcomes of care collected from records after discharge.

Results: Records of 204/210 cases of delirium identified over 3 months were reviewed: mean age 81.5±7.3 yrs, 35% male, 19% from institutions. 48% with dementia, illness severity median 5 (IQR 3-6). Delirium was not noted in 26% nursing and 42% medical notes. Unusual cognitive status (UCS) was not recorded in 25% nursing and 49% medical notes. Mental test score (MTS) was attempted in 32%. Delirium was recognised more often when UCS (64% v 36%, p<0.001) or MTS (73% v 52%, p=0.006) were recorded. Alcohol history was recorded in 49%, Barthel Index in 47%. Cotsides were used in 36% cases (v 6% non-cases, p<0.001). Sedation was used in 38% cases, multiple sedative drugs in 13%. 49% could see a clock (v 68% non-cases, p<0.001), 10% a calendar (v 23% non-cases, p<0.001). 61% had 1+ ward moves (med. 1 range 0-4). In-hospital mortality 27%. 20% discharged to new institutional care. Med. LOS 18 days (IQR 9-32). 76% had 1+ in-hospital complications: 64% incontinence problem, 30% falls, 33% infection, 19% pressure sores. Cotsides were associated with higher mortality (36% v 22%, p=0.04), falls (% with fall 45% v 22%, p=0.001), pressure sores (29% v 14%, p=0.01), infections (49% v 25%, p=0.001) and longer LOS (med. (IQR) 15(7-27) v 22(11-38), p=0.001).

Conclusions: Delirium is under-recognised, cotsides are overused, RO underused. Deficiencies in the process of care may result in failure to identify the cause of delirium. The association between cotsides and poor outcomes may be due to patient selection (our data do not suggest this), or may reflect sub-optimal management. Recording MTS and UCS is associated with increased recognition of delirium and should be adopted as routine. The accessibility of clocks and calendars is low for cases of delirium, despite the availability on wards.

UNRECOGNIZED DEPRESSION IN ELDERLY HOSPITAL INPATIENTS

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Introduction: Depression is more prevalent in older persons than in any other age group. It has been found to affect up to 35% of medically ill elderly hospital inpatients. Diagnosis is complicated by the high prevalence of depressive symptoms masquerading as somatic complaints. The aim of this study was to establish the incidence of undiagnosed depression in elderly hospital inpatients and to identify medical and social problems which may be contributing to the depressive state.

Methodology: Elderly patients (aged >65yrs) who had recovered from the acute medical episode precipitating admission and were ready for discharge were randomly selected from two elderly care wards. Those who were able to cooperate and willing to take part were asked to complete the 30 item form of the Geriatric Depression Scale (GDS). Data relating to the medical and psychiatric history were obtained from the patients’ notes. 106 patients who were included 79 completed all the questions. Depression was defined as a GDS score of > 14 (I).

Results: Of the 79 patients, 16 had a GDS Score >14. Of these 4 patients received anti-depressants or had a record of depression in their notes. Depression was unrecognised and untreated in 12 patients. Diabetes, stroke, chronic heart and lung disease were associated with depression, while age, gender, marital status, social history, length of stay and type of ward (acute or rehabilitation) were not.

Conclusion: Depression in elderly hospital patients is three times more likely to be missed than diagnosed. Patients with chronic debilitating diseases are at a particular risk of a depressive disorder.

DEPRESSION IN ELDERLY PHYSICALLY ILL PATIENTS SHOULD WE BE MEASURING SOMATIC SYMPTOMS?

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Introduction: Depression is most common in elderly people with physical illness, but the relative importance of the somatic symptoms of depression is unclear.

Methodology: Hamilton Depression Rating Scale (H) and Montgomery-Asberg Depression Rating Scale (M) responses in 100 GMS-AGECAT depressed acute geriatric medical in-patients (mean age 79, 74 F), were compared with those of age- and sex- matched non-depressed patients using Chi squared analyses. The correlation matrix of all items for depressed group was examined.

Results: Any degree of retardation (I8H), and more severe levels of concentration difficulties (M6), loss of energy (H13), insomnia (M4), and anorexia (M5), were highly discriminating (p<0.001). Retardation and concentration loss were associated with anhedonia and low mood, and energy loss was associated with anhedonia. However, insomnia and anorexia did not correlate with mood or anhedonia.

Conclusions: Retardation, concentration difficulties, and anergia should be included in assessing depression severity. Insomnia and