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. Usual 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 underused, 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 in-patients. 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. Of 106 patients who were included 79 completed all the questions. Depression was defined as a GDS score of > 14 (1).

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 recognised 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.

Conclusions: 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 (H8), 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...
anorexia, although more frequent among depressed patients and useful with other symptoms to screen for depression, should be measured separately from depression severity.

A longitudinal follow-up of patients with Parkinson's syndrome who attend a specialist movement disorder clinic.

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Introduction.
Specialist movement disorder clinics (MDC), have in recent years been established to offer more appropriate management of Parkinsonism. These clinics are multidisciplinary focused and provide swift access to a specialist therapeutic interventions and services and allow for accurate diagnosis. We present here outcomes of patients who have attended specialist clinic for approximately three years.

Methods.
Since the establishment of this MDC in early 1993, over 300 patients have been referred for specialist appraisal. The information collected at the clinic is a repeated measure design which is as follows: Demographic details, referral diagnosis, primary/secondary diagnosis, clinical disease severity (Webster), cognitive functioning (MMSE / CAMCOG), motor function (two touch tests with left and right hands, timed 10 metre walks), mood (GDS-15), self-report ADL, multidisciplinary team (MDT) involvement.

Results.
A total of 306 patients were referred to the MDC with a diagnosis of Parkinson's disease (PD), of which 162 (53%) fulfilled the PD brain bank criteria for probable PD. 60 (20%) had Parkinson's syndrome (PS) and 84 (27%) had no evidence of PD. Approximately 86% patients on their first attendance at the MDC had alterations to their pharmacological treatment and this was reviewed at each subsequent attendance at the MDC. The repeat measures for motor functioning, self report ADL and mood for the probable PD group demonstrated significant improvements (p<0.05) after interventions in the clinic.

Conclusion.
This study supports the important role of the MDC in the accurate confirmation of the diagnosis in PD by a specialist. Furthermore regular review in a specialist clinic can assist in appropriate pharmacological and physical interventions.

1Hughes et al, Accuracy of clinical diagnosis of idiopathic parkinson's disease- a clinicopathological study of 100 cases. JNP 1992;55:181-4