APA Delirium Practice Guidelines

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Background: The prevalence of delirium in the hospitalized medically ill is 10-30%, with higher rates in subgroups (e.g., post-operative period, terminal illness). Essential features of delirium include disturbance of consciousness, attention, cognition, and perception.

Aim: The American Psychiatric Association published a practice guideline for the treatment of patients with delirium.

Methods: A panel of experts conducted comprehensive literature reviews including searches using MEDLINE, PsycINFO, and EMBASE covering the years 1966-1998. Multiple drafts were reviewed by other organizations and a large number of other expert individual reviewers.

Main Findings: Delirium in the medically ill is associated with longer hospital stays, increased medical morbidity, and increased mortality. The first priority in intervention is identifying a cause though this is not always possible. A number of validated instruments are now available for the diagnosis of delirium and for rating delirium symptom severity. The EEG usually shows generalized slowing, but is generally not helpful in distinguishing specific causes of delirium. Environmental interventions are generally recommended for all patients with delirium. They include providing an optimal level of stimulation, reducing sensory impairments, making environments more familiar, and providing environmental cues to facilitate orientation. Cognitive supportive measures are also helpful including providing patients with reorientation, reassurance, and information concerning delirium. It is helpful to provide similar information and support to family members. Antipsychotic medications are usually the pharmacologic
treatment of choice. Haloperidol is most frequently used because it has fewer side effects (except for extrapyramidal symptoms) and may be administered orally, intramuscularly or intravenously*. Dosage should be initiated at a low level (e.g., 1-2 mg. every 2-4 hours as needed, less in the elderly) with titration to higher doses for patients who continue to be agitated. Uncommonly, patients have required very high doses (hundreds of mg.). For patients requiring multiple doses, continuous intravenous infusion may be useful. When a more rapid onset of action is required, droperidol can be considered. While some physicians have been using the newer antipsychotic drugs (risperidone, olanzapine, and quetiapine) for delirium, few data are available regarding this use. Because patients receiving antipsychotic drugs for delirium have occasionally developed QT interval prolongation, sometimes leading to torsades de pointes, electrocardiographic assessment is indicated. Benzodiazepenes alone are generally reserved for delirium caused by withdrawal of alcohol or sedative hypnotics. Patients with delirium having difficulty tolerating an adequate dose of antipsychotic drug may benefit from the combination of a benzodiazepene and an antipsychotic. Cholinergic drugs such as physostigmine may be useful when delirium is caused by anticholinergic medications. Opiates should be considered for patients in whom delirium is aggravated by pain. Multivitamin replacement should be given to patients with delirium for whom there is any possibility of B vitamin deficiencies.

Limitations: The major limitation in the development of this practice guideline was the paucity of systematic data. Delirium is difficult to study.

Impact on Internal Medicine: These guidelines represent the state of the art for management of delirium, based on expert consensus and extensive literature reviews. Its comprehensive but succinct information and many references make it an excellent resource for clinicians.
* Intravenous administration of haloperidol has not yet received approval by the FDA.