Part 2: Pain and Symptom Management
Delirium Management

Effective Date: February 22, 2017

Key Recommendations

- Look for and treat reversible causes of delirium.
- Utilize neuroleptics first line for pharmacological treatment.

Definition

Delirium is a state of mental confusion that develops quickly, usually fluctuates in intensity, and results in reduced awareness of and responsiveness to the environment. It may manifest as disorientation, incoherence, and memory disturbance.

Assessment

1. Delirium may be hypoactive, hyperactive or mixed.
2. Look for underlying reversible cause (refer to Fraser Health Authority, Hospice Palliative Care Symptom Guidelines - Delirium/Restlessness at www.fraserhealth.ca/media/07FHSymptomGuidelinesDelirium.pdf)
3. Ascertain stage of illness and whether delirium is likely to be reversible, or terminal and irreversible.
4. Review advanced care plan and discuss goals of care with substitute decision maker.
5. Refer patient/family to Home and Community Care (see *Associated Document: Resource Guide for Practitioners*) or timely access to caregiver support and access to respite and/or hospice care.

Management

1. Treat reversible causes if consistent with goals of care.
2. Avoid initiating benzodiazepines for first line treatment.
3. Avoid use of antipsychotics in patients diagnosed with Parkinson's disease or Lewy Body Dementia.

Delirium Management Algorithm

Hyperlinks indicate additional information available in guideline sections above:
A = Assessment
M = Management

Assessment (A1-3)
- Level of consciousness
- Presence of hallucinations
- Fluctuation of mental confusion

*For clinical features of dementia, depression and delirium, refer to BC Guidelines.ca – *Cognitive Impairment – Recognition, Diagnosis and Management in Primary Care*

Diagnosis

Depression*

Treat as appropriate
Refer to *Palliative Care Part 2 – Depression Management Algorithm*

Delirium*

Non-Pharmacological Interventions
- Environment
- Lighting
- Safety

Assess and treat all reversible causes (M1)
- Full physical exam
- History
- Medication review
- Investigations as appropriate

Pharmacological Treatments

Hypoactive (obtunded) patient
- **AVOID sedatives**
- **Haloperidol:** minimum effective dose to control hallucinations

Hyperactive (agitated) patient

Antipsychotic (M3)
- Start with least sedating and work upwards until agitation controlled
  - haloperidol
  - risperidone
  - loxapine
  - olanzapine
  - quetiapine
  - methotrimeprazine
- **AVOID benzodiazepines**
- **Reassess frequently**

Hyperactive (agitated) patient and compromised patient or staff safety

Sedate with benzodiazepine **(M2)** temporarily in addition to:
- antipsychotic treatment **AND**
- Palliative Care Consult

Palliative Care Consult
Contact local specialist or call hotline: 1-877-711-5757

Delirium not reversible

Palliative sedation therapy
- Reassess frequently

Dementia*

Treat as appropriate
Refer to BC Guidelines.ca – *Cognitive Impairment – Recognition, Diagnosis and Management in Primary Care*

Resources

References

1. Lawlor PG, Gagnon B, Mancini IL, Pereira JL, Hanson J, Suarez-Almazor ME, et al. Occurrence, causes, and outcome of delirium in patients with advanced cancer: a prospective study. Arch Intern Med. 2000 Mar 27;160(6):786–94.
2. Macleod AD. Delirium: the clinical concept. Palliat Support Care. 2006 Sep;4(3):305–12.
3. Gagnon P, Allard P, Mâsse B, DeSerres M. Delirium in terminal cancer: a prospective study using daily screening, early diagnosis, and continuous monitoring. J Pain Symptom Manage. 2000 Jun;19(6):412–26.
4. Canadian Coalition for Seniors' Mental Health. Guidelines on the Assessment and Treatment of Delirium in Older Adults at the End of Life [Internet]. 2010. Available from: http://ccsmh.ca/wp-content/uploads/2016/03/NatlGuideline_DeliriumEOLC.pdf
5. Brown S, Degner LF. Delirium in the terminally-ill cancer patient: aetiology, symptoms and management. Int J Palliat Nurs. 2001 Jun;7(6):266–8, 270–2.
6. Leonard M, Raju B, Conroy M, Donnelly S, Trzepacz PT, Saunders J, et al. Reversibility of delirium in terminally ill patients and predictors of mortality. Palliat Med. 2008 Oct;22(7):848–54.

Abbreviations

IM	intramuscular
IV	intravenous
PO	by mouth
SC	subcutaneous

Appendices

Appendix A – Medications Used in Palliative Care for Delirium and Terminal Agitation

Associated Document

- BCguidelines.ca – Palliative Care: Resource Guide for Practitioners

Appendix A: Medications Used in Palliative Care for Delirium and Terminal Agitation

Tailor dose to each patient; **those who are elderly, cachectic, debilitated or with renal or hepatic dysfunction may require reduced dosages;** consult most current product monograph for this information: http://www.hc-sc.gc.ca/dhp-mps/prodpharma/databasdon/index-eng.php

ANTIPSYCHOTICS[A]						
Generic Name	Trade Name	Available Dosage Forms	Standard Adult Dose	Drug Plan Coverage[B]		Approx. cost per 30 days[C]
				Palliative Care	Fair PharmaCare	
quetiapine[D]	Seroquel®, G	**Tabs:** 25, 100, 200, 300 mg	12.5 to 50 mg PO daily to twice daily	No	Yes, LCA	$1–12 (G) $8–67
loxapine[D]	G	**Tabs:** 2.5, 5, 10, 25, 50 mg	2.5 to 10 mg PO/SC daily to twice daily	Yes, LCA	Yes, LCA	$6–19 (G)
		Inj: 50 mg per mL		Yes	Yes	$543–1086 (G)
risperidone[D]	Risperdal®, G	**Tabs:** 0.25, 0.5, 1, 2, 3, 4 mg	0.5 to 2 mg PO daily to twice daily	Yes	Yes	$7–37 (G) $11–62
	Risperdal M-tab®, G	**ODT:** 0.5, 1, 2, 3, 4 mg		Yes	Yes	$18–66 (G) $27–73
olanzapine[D]	Zyprexa®, G	**Tabs:** 2.5, 5, 7.5, 10, 15, 20 mg	2.5 to 10 mg PO daily to twice daily	No	Special Authority, LCA	$10–83 (G) $59–470
	Zyprexa Zydis®, G	**ODT:** 5, 10, 15, 20 mg		No	Special Authority, LCA	$10–83 (G) $117–467
Haloperidol	G	**Tabs:** 0.5, 1, 2, 5, 10 mg	***Mild restlessness:*** 0.5 to 1.5 mg PO tid	Yes, LCA	Yes, LCA	$13–32 (G)
			Delirium and agitation: 0.5 to 5 mg PO q8h to q4h			$13–92 (G)
		Inj: 5 mg per mL	***Mild restlessness:*** 0.25 to 0.75 mg SC[E] tid	Yes, LCA	Yes, LCA	$469 (G)
			Delirium and agitation: 0.5 to 5 mg SC[E] q8h to q4h			$469–938 (G)
metho-trimeprazine[D]	G	**Tabs:** 2, 5, 25, 50 mg	**Delirium:** 10 to 50 mg SC[E] q30min until relief then 10 to 50 mg PO/SC[E] q8h to q4h	Yes, LCA	Yes, LCA	$20–76 (G)
	Nozinan®	**Inj:** 25 mg per mL		Yes	Yes	$337–1347
OTHER						
phenobarbital[F]	G	**Inj:** 30 mg per mL, 120 mg per mL	Epilepsy/terminal agitation: 60 mg SC[E] bid up to 120 mg tid	Yes	Yes	$14–15 per 1 ml ampule (G)

Abbreviations: G generics; **Inj** Injection; **LCA** subject to Low Cost Alternative Program; **ODT** oral disintegrating tablets; **PO** by mouth; **SC** subcutaneous; **tabs** tablets

[A] Refer to guideline and/or algorithm for recommended order of use.
[B] PharmaCare coverage as of October 2016 (subject to revision). Obtain current coverage, eligibility, and coverage information from the online BC PharmaCare Formulary Search page at pharmacareformularysearch.gov.bc.ca
[C] Cost as of October 2016 and does not include retail markups or pharmacy fees. Generic and brand name cost separated as indicated by (G).
[D] This indication (i.e., delirium) used in practice, but not approved for marketing by Health Canada
[E] This route of administration used in practice, but not approved for marketing by Health Canada.
[F] This indication (i.e., terminal agitation) used in practice, but not approved for marketing by Health Canada