### Delirium Risk Factors

1. Anticholinergic drugs: antihistamines, antiemetics, antipsychotics, antiparkinsonian drugs, antidepressants, antispasmodic (GI)
2. Narcotics
3. Sedative hypnotics
4. Corticosteroids
5. H2 blockers
6. Antibiotics (e.g., fluoroquinolones)

### Evaluation

1. Vital signs & physical exam, including neurologic exam
2. Review medication list, including O-T-C, herbal
3. Alcohol history
4. Targeted metabolic workup (CBC, lites, BUN/Cr, Glucose, LFTs, Calcium, U/A, PO2, EKG, Chest x-ray)
5. Search for occult infection (LP should be performed if sign of meningitis present)

### Management

1. Identify and treat underlying cause
2. Non-pharmacologic
   - Use families or sitters as first line
   - Avoid physical restraint
   - Reduce noise, have staff reorient patient
   - Provide eyeglasses, hearing aid
3. Pharmacologic management reserved for patients with severe agitation that causes interruption of therapy and/or poses safety hazard to patient or staff.
   - Use low-dose high potency antipsychotics.
   - Haloperidol (Haldol): 0.25 mg → 0.5 mg PO or IM (IV short-acting ↑ risk of torsades), 0.5 mg – 1 mg parenterally in severe cases. Repeat dose q 30 minutes until sedation achieved (max haloperidol dose=3-5 mg/24 hours). Maintenance 50% loading dose in divided doses over next 24 hours. Taper dose over next few days.
   - Benzodiazepines (e.g., Lorazepam) 0.5 to 2 mg q 4 to 6 hours if delirium secondary to alcohol or benzodiazepine withdrawal.

### Discharge Plan

1. Low threshold to admit
2. Admit elderly patient with delirium
3. If patient is discharged home:
   - Document support in the home environment to manage patient care
   - Plan for medical follow-up
   - Call primary care physician

* Delirium mnemonic was based in part on a mnemonic developed by University of Texas Southwestern Medical Center (SAGE).

### References