Prise en charge du delirium en milieu hospitalier

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Aucun conflit d’intérêt

Objectifs de la présentation

- Au terme de cette présentation, le participant sera en mesure de :

  - Comprendre l'approche globale du delirium en milieu hospitalier
  - Disposer d'outils cliniques (littérature, échelles)
  - Comprendre l'approche de plusieurs cas complexes

Pourquoi s’en préoccuper ?

- Perte d’indépendance
- Morbidité fonctionnelle
- Mortalité
- Prévention réduit incidence, durée et sévérité
- Durée des hospitalisations

Épidémiologie

- Chez la personne âgée :
  - Incidence en hôpital : 6 à 56 %
  - Prévalence à l'admission : 14-24%
  - Incidence post Chx : 15 à 53%
    - Post Chx générale : 10-15%
    - Post Chx cardio-thoracique : 25-35%
    - Post Chx Fx de hanche : 40-50%

Définition DSM-V

- Perturbation de la conscience (Attention)
- Modification du fonctionnement cognitif (mémoire, désorientation, langage, perceptuel)
- Installation rapide (heures ou jours) et fluctue dans le temps
- Due aux conséquences physiologiques directes d'une affection médicale
- Non expliqué par une autre condition neuro cognitive (ex: démence // *TNCM*)

Définition DSM-V

- Sous-types :
  - Hyperactif
  - Hypo-actif (plus chez personne âgée)
  - mixte

Review article (Inouye)

- Delirium in the Elderly, Tammy T (and coll), Clin Geriatr Med 36 (2020) 183-199
  - Épidémiologie
  - Critères Dx
  - Évaluation
  - Mécanismes pathophysiologiques
  - FR
  - Prévention et Tx
  - Médicaments comme FR (Beers)

Tableau clinique (Inouye)

- Début aigue
- Évolution fluctuante
- Déficit attentionnel
- Pensée désorganisée (discours / contenu)
- Altération du niveau de conscience
- Déficits cognitifs (désorientation, mémoire, langage)
- Troubles perceptuels (30%)
- Changements psychomoteurs (sous-types)
- Altération du cycle veille-sommeil
- Troubles émotionnels

Précipitants // perpétuants

- I WATCH DEATH
  - **I**nfection (HIV, sepsis, Pneumonie)
  - **W**ithdrawal (Alcool, barbituriques, benzo)
  - **A**cute metabolic (Acidose, alcalose, trouble électrolytique, insuffisance rénale)
  - **T**rauma (trauma crânien, grands brûlés)
  - **C**NS pathology (longue liste…)
  - **H**ypoxia (Anémie, intoxication au monoxide de carbone, hypotension, insuffisance cardiaque et pulmonaire)

Précipitants // perpétuants

- **D**eficiencies (Vitamine B12, acide folique, niacine (B3), thiamine (B1))
- **E**ndocrinopathies (Hyper/hypoadrenocortisolisme, hyper/hypoglycémie, Myxœdème,hyperparathyroïdies)
- **A**cute vascular (encéphalopathie hypertensive, AVC, arythmie, Choc)
- **T**oxins or drugs (médication, drogues illicites, pesticides, solvants)
- **H**eavy Metals (plomb, manganèse, mercure)

Classique Dx Diff D/D/D

Table 1.1 – Differentiating Delirium, Depression, and Dementia

	Delirium	Dementia	Depression
Onset	Acute	Insidious	Variable
Duration	Days to weeks	Months to years	Variable
Course	Fluctuating	Slowly progressive	Diurnal variation (worse in morning, improves during day)
Consciousness	Impaired, fluctuates	Clear until late in the course of the illness	Unimpaired
Attention & Memory	Inattentive Poor memory	Poor memory without marked inattention	Difficulty concentrating; memory intact/minimally impaired
Affect	Variable	Variable	Depressed; loss of interest and pleasure in usual activities

Delirium « qui ne finissent pas »

- Présence « neuro-fragilisé »
  - TNCM
  - Atrophie marquée pour l'âge
  - Post AVC

- The inter-relationship between delirium and dementia : the importance of delirium prevention, Nature reviews, Neurology, vol 18, octobre 2022, p.579-596
  - Facteurs inflammatoires
  - Appauvrissement cérébral
  - Table 1, signes // sx distinctifs delirium vs démence

Delirium « qui ne finissent pas »

- delirium ou démence // **delirium ET démence**
- Outils
  - CAM (confusion assessment method)
  - 3D-CAM (3 minutes)
    - 12 items
    - Manuel en ligne

Delirium « qui ne finissent pas »

- **delirium ET démence**
- Outils
  - 4AT
    - Score jusqu'à 4+
  - OSLA + test d'Attention (lettre comme dans MOCA)
    - Observational Scale of Level of Arousal (Score 0 à 15)
    - 4 ou plus
      - Sensibilité 0.94
      - Spécificité 0.92

Delirium « qui ne finissent pas »

- **4AT :** discriminer entre delirium et démence
  - (score 0 jusqu'à 4 par item)

- [1] ALERTNESS (Vigilance) : 10 secs d'éveil
  - 0 ou 4 points
- [2] AMT4 (orientation) :
  - Âge, date de naissance, lieu, année
  - erreur 1 = 1 point; erreurs 2+ = 2 points
- [3] ATTENTION :
  - Mois de l'année « à l'envers »
  - moins 7 // refus de collaborer = 1 point
  - Non testable (moche, somnolent, inattentif) = 2 points
- [4] ACUTE CHANGE OR FLUCTUATING COURSE
  - 0 ou 4 points

- *4 or above: possible delirium +/- cognitive impairment*
- *1-3: possible cognitive impairment*
- *0: delirium or severe cognitive impairment unlikely (but delirium still possible if [4] information incomplete)*

Delirium « qui ne finissent pas »

- **OSLA**
- 4 items à évaluer :
- *Eye opening*
- *Eye contact*
- *Posture*
- *Movement*

Delirium « qui ne finissent pas »

- **OSLA** – item 1
- **Eye opening**
- *0 Open on arrival and remain so, under patient's control, outlasts stimulus*
- *1 Open on arrival but close if stimulus removed*
- *1 Open to voice but then outlasts stimulus*
- *2 Open to voice but close if stimulus removed*
- *3 Open to gentle physical stimulation (squeezing hand, gently shaking shoulder)*
- *4 Open to pain only*
- *5 No eye opening*

Delirium « qui ne finissent pas »

- **OSLA** – item 2
- **Eye contact**
- *0 Spontaneously makes and holds eye contact appropriately*
- *1 Drowsy and makes eye contact to command but cannot hold it for very long*
- *1 Alert but eyes wandering, some appropriate eye contact*
- *2 Alert but eyes wandering, little or no appropriate eye contact*
- *2 Drowsy but makes brief eye contact*
- *3 Eyes will/are open but no eye contact*

Delirium « qui ne finissent pas »

- **OSLA** – item 3
- **Posture** (NB take into account weakness due to stroke or neurological disease)
- *0 Sitting out in chair or up in bed, holding appropriate posture*
- *1 Slumped in chair or bed but attempts to sit upright and sustain posture on request*
- *2 Slumped in chair or bed and unable to sustain posture*
- *3 Lying in bed and unable or no response to request to sustain posture*

Delirium « qui ne finissent pas »

- **OSLA** – item 4

- **Movement**
- *0 Moves spontaneously and purposefully with no restless or agitated movements*
- *1 Occasional or mild restless or fidgety movements, no aggressive or vigorous movements*
- *1 Reduced frequency of movement, mildly slowed up*
- *2 Frequent restless or fidgety movements, no aggressive or vigorous movements*
- *2 Moderately reduced frequency and speed of movement, interfering with assessment or self-care*
- *3 Aggressive or vigorous, recent pulling out of lines*
- *4 Overtly combative, violent*
- *4 Severely reduced frequency and speed of movement, few spontaneous movements*

Traitement / prévention(HELP)

- Orienter dans les 3 sphères
- Mobilisation précoce
- Lunettes // appareil auditif
- Hydratation
- Alimentation // élimination
- Hygiène de sommeil
- Réduction polyRx et psychotropes
- Implication des divers intervenants de la santé
- Implication de la famille

Traitement / prévention(HELP)

Table 5 | **Suggested adaptations to delirium prevention interventions for individuals with dementia**

Targeted risk factor	Interventions	Description	Adaptation for dementia
Cognitive impairment	Orientation protocol	Orientation board with names of care team members and daily schedule; orienting communication once a day	Orientation protocol three times a day; education for staff in special approaches to communication with individuals with dementia
	Therapeutic activities	Cognitive stimulation activities three times a day (customized selection according to leisure interests and physical impairments)	Additional customization for the selection of activities according to level of cognitive function
Immobility	Early mobilization	Walking or active range-of-motion exercises three times a day; minimizing use of immobilizing equipment and physical restraints	For all tasks, focus on one-step, as opposed to multistep, instructions
Vision impairment	Vision protocol	Providing visual aids and adaptive equipment, with daily reinforcement	For all tasks, focus on one-step, as opposed to multistep, instructions
Hearing impairment	Hearing protocol	Providing portable amplifying devices; earwax disimpaction; special communication techniques, with daily reinforcement	For all tasks, focus on one-step, as opposed to multistep, instructions
Dehydration	Oral volume repletion	Early recognition of dehydration and oral volume repletion; encouragement during meals	For all tasks, focus on one-step, as opposed to multistep, instructions
Sleep deprivation	Non-pharmacological sleep protocol	At bedtime, warm drink, relaxation music or sounds, and massage; unit-wide noise reduction programme; rescheduling medications and procedures to allow uninterrupted sleep	Importance of behavioural (for example, avoid caffeine and diuretics after mid-day) and environmental changes to enhance sleep (for example, darkened, quiet room, minimize interruptions)
Polypharmacy and inap-propriate medications	Psychoactive medications protocol	Screen medications daily; minimize medications listed in AGS Beers Criteria and psychoactive medications; discuss strategies with an interdisciplinary team	Avoidance of psychoactive medications even more important for this high-risk group
Other protocols	Nursing interventions	Targeting delirium risk factors (as above) in all patients, with special nursing focus to maintain early mobility, prevent dehydration, avoid psychoactive medications and maximize sleep hygiene; use of non-pharmacological approaches for sleep, anxiety or pain	Daily delirium screens with medical work-up as indicated; minimizing psychoactive medications; non-opioid treatments for pain; educating patients, families and staff about behavioural management in dementia and sundowning
	Provider education	Educational programme about delirium and delirium prevention	Educational programme about delirium superimposed on dementia; special needs of dementia patients; behavioural management of agitation
	Emotional support	Nursing, chaplaincy, social work support	Include family and informal caregivers

Traitement pharmacologique

- Aucun
- Gestion de l'agitation
  - Bz uniquement pour DT // sevrage Bz
  - Si risque pour soi // autrui : antipsychotiques (Qtc)
    - Haloperidol (0.25mg à 1mg)
    - Quetiapine (6.25 mg à 25 mg)
    - Si Qtc élevé
      - Loxapine (2.5 mg à 5 mg) IM, *10 mg = 2 mg haloperidol*
      - Perphenazine (1 mg à 2 mg), *8 mg = 2 mg haloperidol*

Vignettes cliniques

- Différencier cause primaire de cause secondaire

  - Post AVC
  - Post TCC
  - Anoxie cérébrale

Vignettes cliniques

- Corticostéroïdes

  - Asthmatique : saturation
  - Néoplasie
  - Masse inflammatoire intra cérébrale
    - Status epilepticus surajouté?

Vignettes cliniques

- Perfusion cérébrale

  - Hypotensions
  - Insuffisance cardiaque
  - Anémie importante

Vignettes cliniques

- Trouble lié à l’usage de l’alcool sévère et chronique
  - Delirium tremens
  - Wernicke
  - Encéphalopathie hépatique

Questions

Courte bibliographie

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- Diagnosing delirium in âtients with dementia, a great challenge, Neus G and coll, Med Clin, 2019:153(7):284-289
- The inter-relationship between delirium and dementia : the importance of delirium prevention, Nature reviews, Neurology, Tamara G Fong and coll, vol 18, octobre 2022, p.579-596
- Effect of the Tailored, Family-involved HELP program on postoperative delirium and function in older adults, Yan-Yan Wang and coll, JAMA intern Med, 2020 Jan, 180(1):17-25
- Diagnosis, prevention, and management of delirium in the intensive cardiac care unit, Alejanfro Cortes-Beringola and coll, Am Heart J, 2021; 232:164-176
- Prevention and management of delirium in the ICU, Matthew F. Mart and coll, Demin Respir Crit Care Med, 42(1):112-116
- HELP
- Échelles :
  - 4AT
  - OSLA
  - 3D-CAM