Case Report

Delirium in an Unwell Elderly Patient - Psychiatrist in Palliative Care

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KEYWORDS: Delirium, Elderly, Palliative Care, Advance Directive

RUNNING TITLE: Delirium Management in Geriatric Patient: Psychiatrist in a Palliative Care Role

BACKGROUND:

End of life care is increasingly becoming complex and protracted with the advances in critical care medicine.[1] Prolongation of life in critically ill elderly comes with multiple issues related to ethics, quality of life and autonomy of the patient, care giver burden, financial issues, and interplay of complex medical issues affecting the well being of the patient and the caregiver.[2] Palliative Psychiatry is increasingly being recognised as a major subspecialty when it comes to dealing with these situations.[3] There is a high incidence of delirium in end stage palliative care with a prevalence as high as 88%[4]. Here we report a patient with multiple critical medical issues who suffered with severe and protracted delirium. He was brought in owing to unmanageable aggression and sleep wake cycle reversal which made the caregivers totally helpless. The complexities in his care and considering the family's wishes for not having any invasive treatment procedures are being discussed.

CASE PRESENTATION:

Mr X, a 83 year old man was brought to the specialty clinic in the tertiary care hospital following fluctuating levels of consciousness, confusion, aggressive behavior, and altered sleepwake pattern of two and a half months duration, which had worsened in the two weeks prior to admission in the ward. There was difficulty in feeding him and ensuring cleanliness following micturition or defecation and to bathe him. There was an almost continuous disturbance in sleep every night with threatening gestures and shouting which completely exhausted the family and support staff employed in his care.

The patient had been independent in his activities of daily living and fully functional a year before. A series of worsening medical conditions made him completely dependent and requiring full time assistance and care. At the time of admission, he had severe mitral valve prolapse, mitral regurgitation, third degree heart block (no pace maker), hypertension, diabetes mellitus, benign prostatic hypertrophy on catheter, recurrent urinary tract infection, stage II chronic kidney disease and persistent hyponatremia resistant to correction.

Following the first visit to the hospital, he was commenced on low dose of Quetiapine 25 mg, which did not bring about any significant clinical improvement. It was changed to Risperidone 1mg, Lorazepam 2mg at night and Olanzapine 5mg as PRN if he became extremely aggressive. It caused excessive sedation and subsequently he was brought in to the hospital for admission to optimise general medical condition, nutrition and delirium.

During the previous year, he had 4 admissions, the first one in Feb 2019, following urinary flow obstruction due to benign prostatic hypertrophy. A foley's catheter was placed since then. The 3 admissions following that in April, May and June were due to altered sensorium.

Urinary tract infection and hyponatremia were detected and treated each time. In mid-October, similar phase of altered sensorium led to another admission in another hospital and he had persistent low sodium levels (< 120 meq/dl) which was considered intractable by the nephrology team. This had led to protracted delirium and significant distress to caregivers.

Post admission, his general condition was noted to be poor, with evidence of low body weight, refusal to feed, fluctuating consciousness and difficulty in communication. General examination revealed no specific findings attributable to cardiovascular or respiratory system decompensation apart from the chronic illnesses. Baseline blood investigations including Hb, TC, DC, ESR were normal. Blood urea and serum creatinine did not show any change from previous values. LFT, CRP, urine routine were within normal limits, and urine culture did not show any growth of pathogens. Serum electrolytes showed Sodium level of 118 and Potassium level of 4. ECG revealed prolonged QTc. Chest X ray showed calcification of right pleural base, but free costophrenic and cardiophrenic angles. CT scan brain did not reveal any major findings which could have explained the behavioural changes. EEG could not be done, as the patient was not cooperative or able to follow simple commands. USG abdomen did not reveal significant abnormality of visualised organs.

Initial correction of sodium with concentrated saline and supplements did not benefit the patient. Trial of Risperidone 0.5 mg BD alone helped reduce the aggressive behaviour, however titration of dose to 1mg BD led to mild extrapyramidal side effects and worsening of QTc. This made the treating team reduce the dose of medicine to the minimum.

Possibility of SIADH was considered by the home team as a reason for persistent hyponatremia as the patient was euvolemic and did not show evidence of renal or gastric wastage of sodium. Urinary osmolality was high (355 mOsmol/kg) and Blood Osmolality was low (258 mOsmol/kg) which was indicative of SIADH. Nephrology consultation was requested in view of the findings, and the patient's sodium levels were normalized with a combination of fluid restriction, concentrated sodium infusion and general care. There was considerable improvement in the patient's mental status, with resolution of symptoms of delirium, and regaining some ability to verbally communicate coherently, improved sleepwake rhythm, and better dietary intake. The dose of risperidone was reduced to 0.5 mg and then stopped in 3 days. The QTc interval remained prolonged and the heart block persisted. Lurasidone was recommended as the drug of choice if at all the need for antipsychotic arose again in view of lesser risk of worsening QTc.

The family members had opted against any invasive cardiac intervention as it was the patient's expressed wish. He was discharged at request and transferred to his home in Bangalore. He was apparently well for a week, and was reportedly quite happy to meet many of his friends and relatives there, participating in conversations with them. He passed away in his sleep a week later due to unknown reasons.

DISCUSSION:

The index patient raised multiple dilemmas while providing care as a psychiatry team which was part of the geriatric care clinic, starting with the initial outpatient visit and during and after the stay in the hospital. Most of these are quite common with the elderly patients presenting to tertiary care hospitals. Managing multiple medical issues and multiple specialists, addressing care giver burden, impact of protracted delirium, identifying its cause and correcting it, treatment decisions related to multiple systemic issues, coordination among specialists, expectations and wishes of the patient and family as well as clearly defining the goals to be achieved following admission are some of the important aspects of geriatric medical care. Current socio-demographic trends and increasing specialization of medical care have prolonged life, albeit at the huge cost of declining quality of life and increasing medical expenditures.[5] Patients and family members are faced with bewildering choices and many at times left with no participatory roles in making treatment decisions.

Psychiatrists are increasingly involved in end stage of life issues and palliative care and are requested for liaison work with specialists to manage delirium and behavioral problems due to varying etiologies.[6] While the role of pain management in palliative care is well known, managing delirium in this group is not given adequate importance though it can be the most distressing problem for both the patient and the caregiver[4].The index patient was functionally independent a year ago, and the recurrent delirium had kept him completely dependent and caused severe care giver distress. The appropriate diagnosis and management of the etiology of delirium was all that the family looked forwarded to.

Advance directives by elderly patients is given importance less commonly in India, and most of the treatment decisions are taken by immediate kin. It is being increasingly recognised that quality of life and comfort needed to be given priority in end of life care where adventurous treatments become futile. That the society is living up to these realities is evidenced by recent amendments in the constitution and important judgements by the Courts.[7] Advanced directives at the same time is also critiqued as insufficient in view of its utility, effectiveness and the dynamic nature of individual's choices and availability of services.[8] [9] [10] Our patient had made an expressed wish not to have invasive treatment when competent a year ago, but following the onset of delirium, there was no way to understand his wishes and current attitudes towards treatment of other medical issues which were life-threatening. Following the resolution of delirium, he repeatedly expressed his wish to be back in his native town, though no meaningful decision could be taken regarding insertion of pacemaker to address the heart block in an already compromised heart owing to severe MVP and MR. The patient's two daughters decided not to have invasive cardiac treatment when poor prognosis was explained to them. The appropriateness of the decision was discussed with both daughters and the many specialists involved in the patient care and consensus arrived at. The series of conversations in the beginning clearly defining the purpose of admission, goals of treatment and the acceptance of death as an outcome enabled the treatment team to work on improving the clinical situation, so as to enhance the quality of life and reduce suffering in the patient.

In short, the patient and the family members gave invaluable insights into how complex issues could be handled maturely, while focusing on the most salient issues affecting patient well-being. In this case, it turned out to be behavioural issues brought about by delirium. Multi-disciplinary inputs made a meaningful difference not only in managing the patient's problem, but also in mitigating care-giver burden. It also highlighted the need for psychiatric inputs for patients in end stages of life, in liaison with medical care and palliative care for addressing complications like delirium, addressing grief, assessing competency and facilitating discussions around treatment choices and decisions.

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