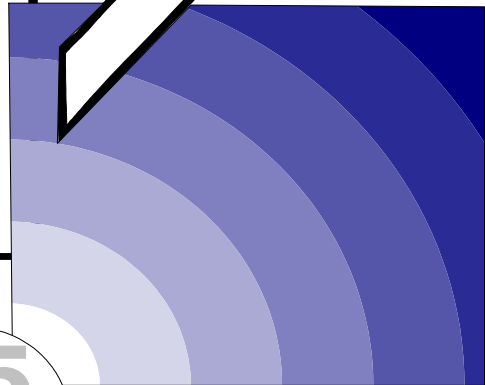
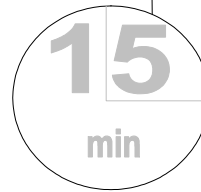


# CLIP

15 minute Worksheet



## Helping patients with symptoms other than pain

### 9: Confusion

Intermediate level

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#### Aim of this worksheet

To review the features and causes of confusional states, and to consider how to help

#### How to use this worksheet

- You can work through this worksheet by yourself, or with a tutor.
- Read the case study below, then work on the questions overleaf.
- The work page is on the right side, the information page is on the left.
- Work any way you want: you can try answering from your own knowledge (in which case fold over the information page), you can use the information page (this is not cheating- you learn as you find the information), or you can use other sources of information
- It should take you about 15 minutes. If anything is unclear, discuss it with a colleague.
- If you think any information is wrong or out of date let us know
- Take this learning into your workplace using the activity on the back page.

#### Case study

**John is a 54 year old man who had surgery for a carcinoma of the colon. Two weeks ago his wife noticed he seemed vague on occasions. Over the past week he has become increasingly disorientated. At times he has been agitated and suspicious of anyone visiting.**

### Confusional states

*Acute confusional states* are the commonest form of confusion in advanced disease. It is present if there are 4 or more typical features. Six are highly specific: acute onset, fluctuating course, disorganised thinking, inattention, memory impairment, and disorientation. Five are less specific: altered sleep-awake cycle, abnormal psychomotor activity, altered level of consciousness, and perceptual disturbance.

*Chronic confusional states* are seen in the dementias. They can have similar features to acute states, but the history is longer, the symptoms fluctuate less, and the patient's alertness is unlikely to have changed.

### Features of confusion

**Memory failure:** this is common in confusional states and is usually due to a reversible failure to take in information. In the dementias there is a failure to retain information because of irreversible cortical damage.

**Alteration in alertness:** in acute confusional states this can be either an increase or decrease in alertness. In chronic confusional states alertness is usually unchanged.

**Impaired concentration:** this can occur independently of any change in alertness. An extreme form is seen in 'frozen terror' where severe anxiety produces a state of immobility and withdrawal.

**Abnormal experiences:** misperceptions and hallucinations need to be differentiated. *Misperceptions* have an external stimulus and occur with reduced alertness or concentration. A patient may think they see someone to one side, only to turn and find no-one is there. *Hallucinations* are much less common, have no outside stimulus and persist in being real to the patient. This differentiation is important with morphine since misperceptions will usually disappear as tolerance to drowsiness occurs, whereas hallucinations require a change in dose or opioid. It is possible that misperceptions and hallucinations are at the opposite ends of the same spectrum of abnormal experiences.

### Clinical decisions and causes of confusion

- **Is memory failure present?**

If the history suggests several months of problems with no change in alertness and slow deterioration then this suggests dementia. Otherwise suspect organic failure of memory eg. cerebral tumour (an unusual cause of confusion)

- **Has alertness changed?**

Check for: dehydration; drug started recently; chemical withdrawal (drugs, alcohol, tobacco); infection; biochemical cause (hypercalcaemia, uraemia, inappropriate ADH secretion; cardiac disease; respiratory disease (infection, pulmonary embolus, pleural effusion, pulmonary metastases); recent trauma (long bone fracture, subdural haematoma). Infections, drugs and biochemical causes are the commonest causes. Hypercalcaemia should always be suspected in patients with cancer who have unexpected confusion.

- **Is concentration impaired?**

*In the presence of anxiety:* fear, depression, communication problems, or social problems may be the cause.  
*In the absence of anxiety:* consider distraction as a cause (eg. pain)

- **Is the patient experiencing unusual sights or sounds?**

*If misinterpreting an external stimulus:* consider the causes of altered alertness above.

*If hallucinating (ie. no external stimulus):* consider causes such as drugs, chemical withdrawal or psychiatric illness.

- **Has behaviour altered?** Consider causes such as memory failure (see above), drugs and psychiatric illness.

### Simple approaches

*Explanation:* confusional states can be frightening for all involved: the patients fear they are 'losing their mind' while carers feel uneasy at the unpredictability of the patient's words and actions. Confused patients can understand explanations, although if their concentration is impaired this explanation may have to be repeated several times.

*Stable environment:* it helps to keep the environment quiet and light, while keeping staff changes to a minimum.

*Re-orientation:* repeated, gentle reminders of place, time and people provide 'hooks on which to hang their reality'.

### Urgent control of disturbance

Occasionally the behaviour risks harm to the patient or others. Because escape and paranoia are two common features, it may take a great deal of explanation and a calm, well-lit environment. If medication is unavoidable, it is best to start with drugs with minimal sedation unless the disturbance is severe. In the absence of abnormal behaviour, anxiety and fear are prominent and benzodiazepines will help suppress the anxiety to a level that is manageable for the patient. When abnormal behaviour is present, antipsychotic medication is needed, although a few patients need both.

- **In absence of abnormal experience or behaviour:**

*For minimal sedation:* lorazepam 0.5-1mg PO or sublingually.

*If sedation is required:* midazolam 2-10mg SC or sublingually 1-hourly as required (or as a continuous infusion)

- **In the presence of abnormal experience or behaviour:**

*For minimal sedation:* haloperidol 2.5-10mg once at night PO or SC, or risperidone 0.5-2mg at bedtime.

*If sedation is required:* olanzepine PO 5-10mg daily or levomepromazine (methotrimeprazine) 12.5-100mg 8-hourly PO or SC (or as a SC infusion 25-300mg per 24 hours).

- **In the presence of aggression:**

Haloperidol 2.5-10mg PO or SC at bedtime, or risperidone 0.5-2mg at bedtime.

**Write**

**Ring** the features which are typical of these two types of confusional state

| <b>Acute confusional state</b><br>eg. infection   | <b>Chronic confusional state</b><br>eg. dementia  |
|---|---|
| acute onset<br>long history<br>slow deterioration<br>poor concentration<br>memory failure<br>disorientation<br>altered sleep-awake cycle<br>changes in alertness<br>alertness unchanged | acute onset<br>long history<br>slow deterioration<br>poor concentration<br>memory failure<br>disorientation<br>altered sleep-awake cycle<br>changes in alertness<br>alertness unchanged |

**Reflect**

**Think about possible causes of John's confusion**

- Most likely:
- Less likely:

**Write**

**List some simple approaches you could take to help John**

**Reflect**

**Think about what would make you feel that urgent control of the confusion with drugs was needed?**

## FURTHER ACTIVITY: Confusion

Think back to the last confused patient you met:

- what simple measures were used to help?

## FURTHER READING: Confusion

### Journal articles

- Brown S, Degner L. Delirium in the terminally-ill cancer patient: aetiology, symptoms and management. *International Journal of Palliative Nursing*. 2001; **7**(6): 266-72.
- Caraceni A, Nanni O, Maltoni M, Piva L, Indelli M, Arnoldi E, Monti M, Montanari L, Amadori D, De Conno F. Impact of delirium on the short term prognosis of advanced cancer patients. Italian Multicenter Study Group on Palliative Care. *Cancer*. 2000; **89**(5): 1145-9.
- Foreman MD, Wakefield B, Culp K, Milisen K. Delirium in elderly patients: an overview of the state of the science. *Journal of Gerontological Nursing*. 2001; **27**(4): 12-20.
- Hughes A. Recognising the causes of delirium in older people. *Nursing Times*. 2001; **97**(33): 32-3.
- Inouye SK, van Dyck CH, Alesi *et al*. Clarifying confusion: the confusion assessment method- a new method for detection of delerium. *Annals of Internal Medicine* 1990; **113**: 941-948.
- Katz IR, Jeste DV, Mintzer JE, Clyde C, Napolitano J, Brecher M. Comparison of risperidone and placebo for psychosis and behavioral disturbances associated with dementia: a randomized, double-blind trial. Risperidone Study Group. *Journal of Clinical Psychiatry*. 1999; **60**(2): 107-15.
- Lawlor PG, Gagnon B, Mancini IL, Pereira JL, Hanson J, Suarez-Almazor ME, Bruera ED. Occurrence, causes, and outcome of delirium in patients with advanced cancer: a prospective study. *Archives of Internal Medicine*. 2000; **160**(6): 786-94.
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- Lawlor PG. The panorama of opioid-related cognitive dysfunction in patients with cancer: a critical literature appraisal. *Cancer*. 2002; **94**(6): 1836-53.
- Loneragan E, Luxenberg J, Colford J. Haloperidol for agitation in dementia (Cochrane Review). *The Cochrane Library*, 2002; Issue 2. Oxford: Update Software Ltd. ([www.cochrane.org](http://www.cochrane.org))
- Morita T, Tsunoda J, Inoue S, Chihara S. Survival prediction of terminally ill cancer patients by clinical symptoms: development of a simple indicator. *Japanese Journal of Clinical Oncology*. 1999; **29**(3): 156-9.
- Schuermans MJ, Duursma SA, Shortridge-Baggett LM. Early recognition of delirium: review of the literature. *Journal of Clinical Nursing*. 2001; **10**(6): 721-9.
- Shury A. Managing delirium in the palliative care of older people. *Nursing Older People*. 2002; **14**(4): 16-8.
- Wakefield B, Johnson JA. Acute confusion in terminally ill hospitalized patients. *Journal of Gerontological Nursing*. 2001; **27**(4):49-55.

### Resource books and websites

- Stedeford A. Confusion. In, *Facing Death: patients, families and professionals, 2nd edition*. Oxford: Sobell Publications, 1994
- A Guide to Symptom Relief in Palliative Care, 5<sup>th</sup> ed*. Regnard C, Hockley J. Abingdon: Radcliffe Medical Press, 2004
- Oxford Textbook of Palliative Medicine* 3rd ed. Doyle D, Hanks G, Cherny NI, Calman K eds. Oxford : Oxford University Press, 2003.
- PCF2- Palliative Care Formulary, 2<sup>nd</sup> ed*. Twycross RG, Wilcock A, Charlesworth S. Abingdon: Radcliffe Medical Press, 2003. Also on [www.palliativedrugs.com](http://www.palliativedrugs.com)
- Symptom Management in Advanced Cancer, 3rd edition*. 2001. Twycross RG, Wilcock A. Abingdon: Radcliffe Medical Press. [www.palliativedrugs.com](http://www.palliativedrugs.com) Updated website for the Palliative Care Formulary

# CLIP

**Current Learning In Palliative care**  
**An accessible learning programme for health care professionals**

### Fifty seven 15 minute worksheets are available on:

- An introduction to palliative care (3 worksheets)
- Helping the patient with pain (9 worksheets)
- Helping the patient with symptoms other than pain (11 worksheets)
- Moving the ill patient (2 worksheets)
- Psychological needs (8 worksheets)
- Helping patients with reduced hydration and nutrition (8 worksheets)
- Procedures in palliative care (4 worksheets)
- Understanding and helping the person with alternative communication (learning disabilities) (5 worksheets)
- The last hours and days (4 worksheets)
- Bereavement (3 worksheets)

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Helping the Patient with Advanced Disease: a Workbook  
Regnard C. ed.

Oxford: Radcliffe Medical Press [www.radcliffe-oxford.com](http://www.radcliffe-oxford.com)