Question and Answer (RCN OP webinar)

Questions	Answers	Speaker
Why is delirium in older adults who have had hip surgery so acute	Half of older adults undergoing surgery will experience delirium. Hip surgery in particular poses an additional risk of developing delirium (compared to other types of surgery) due the extended length of operating time resulting in larger and longer administration of anaesthetics, stress of surgical trauma, stronger pain (and stronger pain killers), more blood loss during surgery, prolonged inflammation and longer period of immobility/recovery. From a pharmacological and pathophysiological perspective, the brains of older adults are less resilient to the stress of surgical procedures compared to younger individuals. This is due to a decline in both 'cognitive and physiological reserves' as people age. A key factor is systemic inflammation resulting from the trauma of the hip break and the operation, which can have a more pronounced effect on older adults, especially those with underlying brain conditions such as vascular dementia or Alzheimer's disease, where the blood-brain barrier may already be compromised. Furthermore, the surgery and anaesthesia itself can disrupt the delicate balance of neurotransmitters, particularly acetylcholine and dopamine, as highlighted in my presentation.	Dio Ahmad
Would you also increase the risk if opioids are abruptly stopped	Opioids increase the risk of delirium and the same applies to abrupt discontinuation of them due to being highly addictive so stopping them abruptly would lead to withdrawal symptoms – rather acute. Opioid drugs have significant anticholinergic properties. Thus, when stopped abruptly, they may cause an acute rebound in cholinergic activity, potentially exacerbating existing delirium, especially in those with compromised cognitive reserves.	Dio Ahmad
How often is review of medication required?	Depends on the medication. For example, blood pressure medications every 6-12 months (depending on the exact medication, the outcomes to achieve and the combination of them diuretics; antipsychotic medications may require 6 weeks, anti-depressants may be longer. Warfarin or Parkinson's medication a lot sooner. If you're a nurse working in adults social care, the GP should	Dio

	review your residents' medications every three months (excluding acute medications, short courses or anti-psychotics/psychotropic meds. If you're a primary care nurse, at every review (e.g. Diabetes review, Hypertension review, Dementia review etc) 6-monthly or annually OR as soon as there are any concerns (e.g, covert medication administration, missing doses, difficulty swallowing, discharge from hospital or upon completion of short course that may stay one if you don't review it on time). Your local medications policy should indicate all the particulars that apply to your practice. Completely agree with Dio. The need for regular monitoring depends on the specific drug in question. Within the context of neurodegenerative diseases, regular review is really important, as these conditions progress over time. For example, in Parkinson's disease, medications (e.g. Sinemet) require careful balance - providing enough to manage symptoms without causing excessive side effects, such as agitation or autonomic disturbances. This makes it essential to regularly assess and adjust medications to ensure optimal efficacy, while minimising adverse effects as the disease advances.	Ahmad
How long is it expected to take for delirium to wear off once treatment for the trigger is started? Such as antibiotics for infection. Can it be residual delirium for a while?	Once all underlying causes leading to delirium are addressed effectively, delirium should subside within hours or days (almost as fast as it appears, disappears). Residual delirium might be present in patients especially in very long hospital stays where they contract hospital acquired infections or become frailer (deconditioned). Underlying condition such as kidney failure, liver cirrhosis, cancers, antibiotic resistance or respiratory failure may prolong delirium to several months but these cases tends to be a lot less common outside of hospital while in hospital they can be found in highly specialist wards/units	
Is there a delirium tool you would recommend for	Sadly not to the best of my knowledge. The available tools tend to be very sensitive and may lead to unnecessary treatment or hospital	Dio

family of dementia clients to use?	admissions. There's literature that suggests QSiD (Single Question in Delirium) might be appropriate but remember families are not medics. Same things would happen if we asked families to use the GCS (Glasgow Comma Scale) at home after a fall. My suggestion is based on "families know best" as they have known their loved ones all of their life and they able to spot soft/subtle/early signs of deterioration in them. Ongoing monitoring is what they can do. What they need is a pathway of clear (easy to navigate) and immediate escalation in their local primary care/community networks to report noticeable changes in their loved one's presentation and receive timely medical advice and/or treatment.	
At what point do you feel it appropriate to commence Haloperidol when treating hyperactive delirium? Difficult to balance the risks in OAs with dementia?	There are very limited groups of people where haloperidol could be used for agitation in the short run (NICE Guideline suggests no longer use than 1 week). In acute situations, other drugs are used such as benzodiazepines or similar with close drug monitoring. Non-pharmacological approaches should be used first to explore the unmet needs before pharmacological interventions are initiated. When dementia and/or depression are also in the picture, very delicate and strategic actions need to be made but by this stage you should have escalated to your local Dementia and Delirium Team to intervene. Remember, if you patient/resident presents with sporadic outbursts of anger or spells of agitations (as a new thing compared to baseline) that's a sign that you need to escalate this to specialists and initiate behaviour charts. Agree with Dio. However, as mentioned in my talk, extreme caution should be exercised when prescribing first-generation typical antipsychotics (D2 antagonists) like haloperidol to individuals with Lewy body diseases, such as Parkinson's disease or dementia with Lewy bodies. These drugs block dopamine receptors, and since dopamine is already severely depleted in in these diseases, their use will likely significantly exacerbate symptoms and have been linked with increased mortality in Parkinson's patients. Additionally, according to NICE guidelines (below), haloperidol should not be given to those with cardiac disorders, pheochromocytoma, central nervous system depression, or neuromuscular weakness (e.g., myasthenia gravis) due to the risk of serious complications.	Dio Ahmad

	https://cks.nice.org.uk/topics/delirium/prescribing-information/haloperidol/	