When Delirium is the Diagnosis, Not Psychosis:

Screening for Delerium in Patients with Serious Mental Illness (SMI) and Dementia

Sharon R. Rainer, PhD, APRN, ENP-C, FNP-BC,PMHNP-BC

Objectives

- Recognize the key differences between delirium and psychosis in emergency settings.
- Understand the impact of serious mental illness (SMI) and dementia on delirium presentations.
- Review evidence-based tools and approaches for screening delirium in patients with SMI and dementia.
- Implement practical strategies to improve diagnosis and outcomes.

Introduction

- Definition of Delirium:

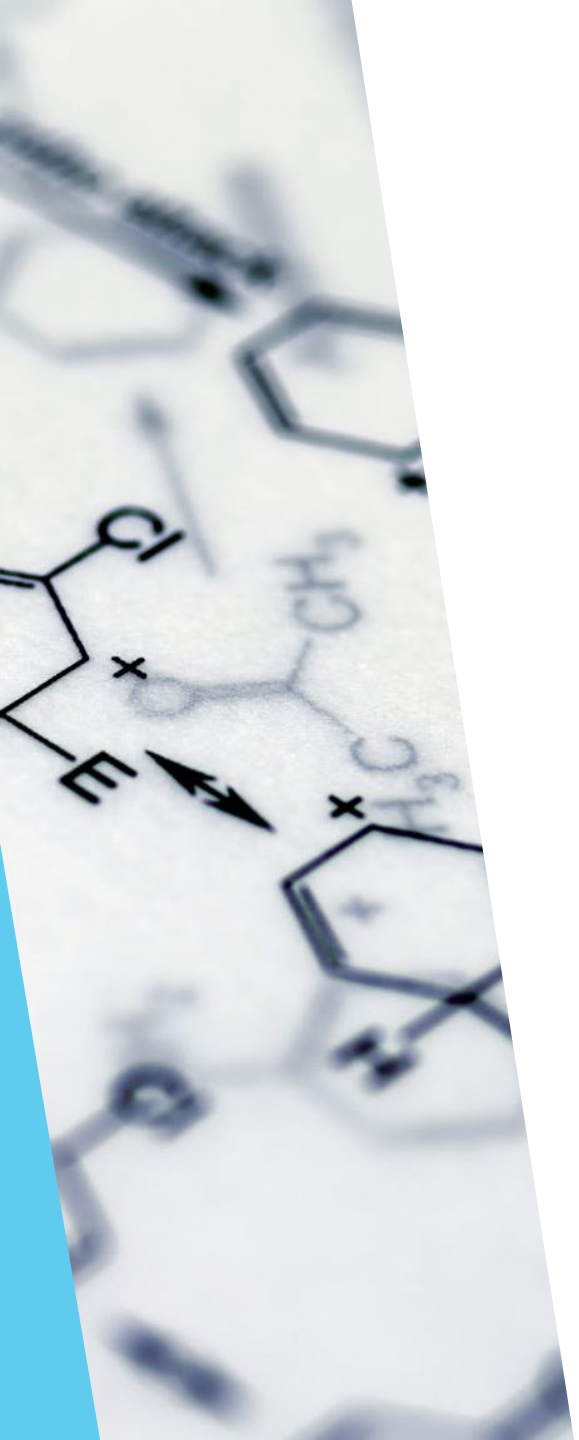
Acute, fluctuating disturbance in attention and cognition caused by underlying medical conditions.

Why It Matters: Delirium often misdiagnosed as psychosis in patients with SMI or dementia. Delayed treatment increases morbidity and mortality.

Delirium vs. Psychosis- Key Clinical Findings

- Delirium: Rapid onset, fluctuating course.
- Disorientation, inattention, altered consciousness.
- Caused by medical conditions (infection, metabolic disturbances, medications).

- Psychosis:Gradual onset, consistent symptoms.Hallucinations, delusions, thought disturbances.Typically linked to psychiatric conditions (schizophrenia, bipolar disorder).



Types of Delirium

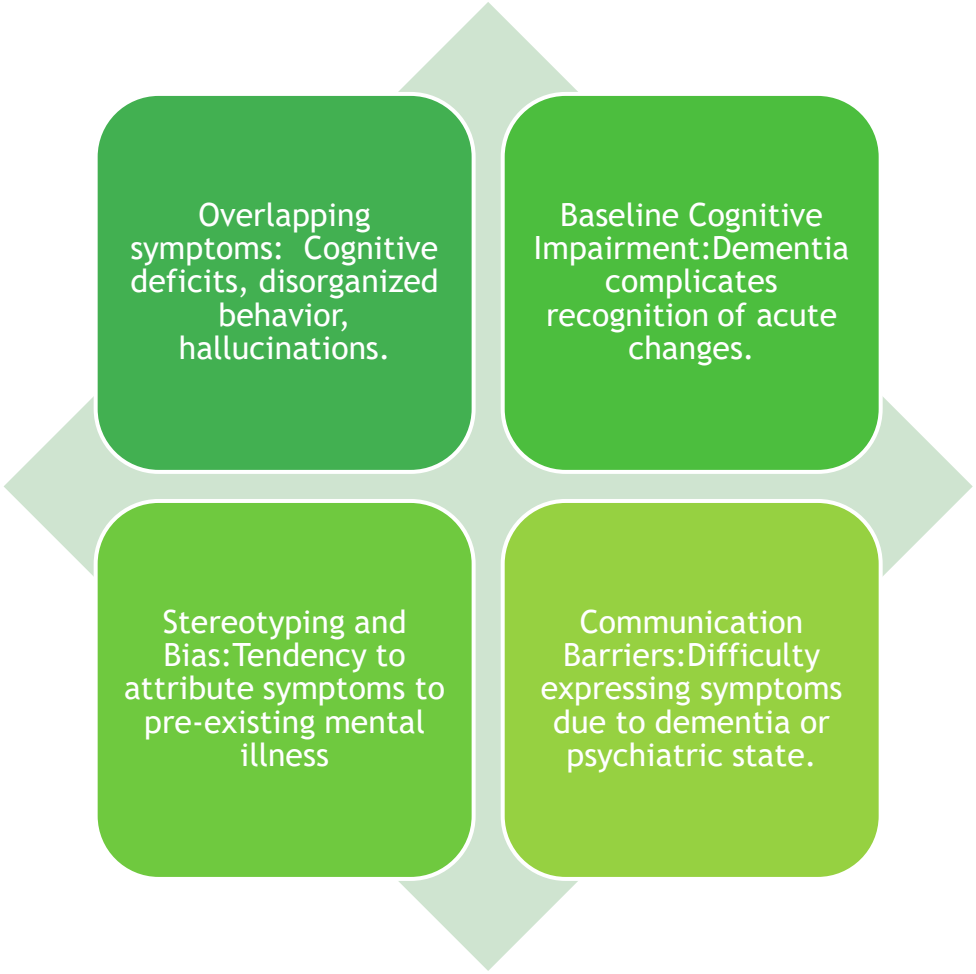
- **Hypoactive**

Hypoactive delirium usually includes inactivity or reduced motor activity. A child may seem sluggish, abnormally drowsy or to be in a daze. Mixed delirium includes both hyperactive and hypoactive symptoms. The child may switch back and forth between these states.

- **Hyperactive**

Children with hyperactive delirium often exhibit erratic behavior, hyperactivity, purposeless movements, and inconsolability.

Challenges in SMI and Dementia



Case Study Patient

- 67-year-old female with schizophrenia and baseline cognitive impairment.
- Frequents the ED (1-2 x daily), Baseline responds to internal stimuli, hears voices, homeless
- BIBFR after Wawa store manager called for “erratic behavior”
- Symptoms: Agitation, swinging arms at staff saying, “you’re trying to kill me”, + visual hallucinations, RIS, confusion.
- Question: Is this psychosis or delirium?
- Discussion: What is the best approach to evaluation?

Pathophysiology of Delirium and Psychosis

- Imbalance in neurotransmitters (e.g., acetylcholine, dopamine).Acute brain dysfunction triggered by systemic stressors (e.g., infection, dehydration, polypharmacy).Increased vulnerability in patients with SMI or dementia.

- Psychosis is a complex condition characterized by disturbances in perception, thought processes, and behavior, often manifesting as hallucinations, delusions, and disorganized thinking. The exact pathophysiology of psychosis is not fully understood, but research suggests it arises from a combination of neurobiological, genetic, and environmental factors.

Risk Factors – Delerium

- Medical: Infection, dehydration, electrolyte imbalance, hypoxia.
- Medications: Anticholinergics, sedatives, polypharmacy.
- Environmental: Hospitalization, ICU settings.
- Baseline Factors: Pre-existing dementia, severe mental illness, frailty.

Screening Tools

- Confusion Assessment Method (CAM):
- Acute onset, inattention, disorganized thinking, altered consciousness.
- 4AT Tool: Rapid screening for alertness, attention, AMT4, acute change.
- Considerations: Adapt tools to the patient's baseline cognitive function. Collaborate with family or caregivers to understand baseline behavior.

Diagnostic Approach

- History:

Recent changes in behavior, medications, or medical history

- Physical Exam:

Look for signs of infection, dehydration, or trauma.

Labs and Imaging: CBC, CMP, UA, chest X-ray, CT head (if indicated).

Differentiating Questions:

Is the change acute?

Are the symptoms fluctuating?

Is there an underlying medical cause?

Management of Delirium

- Identify and Treat the Cause:

Infection, medication toxicity, metabolic derangements.

Non-Pharmacologic Interventions:

Reorient patient (clock, calendar), reduce sensory impairments (glasses, hearing aids).

Medications: Avoid antipsychotics unless agitation is severe and poses risk. Use cautiously in SMI or dementia patients.

- Avoid diagnostic overshadowing (attributing all symptoms to SMI or dementia).Engage caregivers or psychiatric history for accurate baseline information.
- Reassess frequently—symptoms of delirium can fluctuate.

Preventing Misdiagnosis

Communication and Teamwork

- Involve interdisciplinary teams (psychiatry, geriatrics, social work) when possible
- Educate staff on recognizing delirium in high-risk populations.
- Use standardized protocols for delirium screening in ED.

Documentation/ Disposition/ Follow-up

- Clearly document assessment findings and differential diagnosis.
- Plan for appropriate follow-up care (e.g., primary care, psychiatry, geriatrics).

Summary/Key Takeaways

- Delirium is a medical emergency requiring immediate attention.
- Differentiation from psychosis is critical, especially in patients with SMI or dementia.
- Use evidence-based tools for screening and adopt a structured diagnostic approach.

Questions and Discussion

- What would you do differently in the case study?
- How does your ED currently screen for delirium?

References

1. Huang, C., Wu, B., Chen, H., Tao, H., Wei, Z., Su, L., & Wang, L. (2024). Delirium in psychiatric settings: risk factors and assessment tools in patients with psychiatric illness: a scoping review. BMC nursing, 23(1), 464.

2.Springer, B. (2024). Hyperactive delirium with severe agitation. Emergency Medicine Clinics, 42(1), 41-52.

3.Wilson, M. P., Hamrick, E., Stiebel, V., & Nordstrom, K. (2023). Contemporary practices for medical evaluation of the psychiatric patient in the emergency department. Focus, 21(1), 28-34.

Thank You

Sharon.rainer@jefferson.edu