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Confusion 6454 Bart Sheehan and Thomas Jackson

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ESSENTIALS Confusion is a very common presentation in medical patients, especially in older people. It may, but does not always, indicate dementia. Delirium describes a typically brief, fluctuating, and transient state of confusion, which requires a vigorous and urgent hunt for the cause or causes. This is often, but not always, an infection or vascular event. The potential role of prescribed drugs in causing confusion should not be forgotten, and other causes of apparent confusion include depression. Making the diagnosis might take time, and in the meantime it is important to ensure that the physical and nursing arrangements for care keep the patient safe from harm.

Introduction The term confusion is defined as 'The state of being bewildered or unclear in one's mind about something', from the Latin *confudere* 'mingle together'. In clinical settings the term is widely used but not defined, being employed to refer to chronic cognitive impairment (usually dementia) or acute cognitive impairment (usually delirium). The term is used so

frequently as to justify a standardized clinical approach in assessing patients. Common presentations

Vignette 1—A presentation of delirium A 91-year-old female care home resident presents to the emergency department. Her GP has seen her earlier in the day and sends a note stating she is ‘off legs, confused. ?UTI’. She was prescribed trimetho- prim 2 days before. She fluctuates in alertness, and cannot sustain at- tention to questions. A brief examination of lungs, abdomen, limbs, and heart sounds is unremarkable. Further history indicates that the confusion is new. A diagnosis of delirium is made secondary to a urinary tract infection unresponsive to trimethoprim.

Vignette 2—A presentation of dementia A 79-year-old man is admitted from his own home with ‘confusion and agitation’. He has had good physical health, although the referral states he has had ‘memory loss’. He looks after his disabled wife. She reports that over the last 18 months he has begun to care less well for himself, having previously always been very smart. He mixes up days and dates and she has had to take over management of household bills. MRI brain scans show generalized atrophy with more prom- inent volume loss in hippocampal area. A diagnosis of dementia due to Alzheimer’s disease is made. Relevant psychiatric disorders

While dementia will often be the diagnosis, especially in older people, delirium is an important differential diagnosis as it re- quires vigorous further assessment to identify easily treatable causes such as infection and alcohol withdrawal. Depression may also sometimes present with apparent confusion—so-called depressive pseudo-dementia—and is important to identify as it is also treatable. The main differential diagnosis is shown in Box 26.3.1.1.

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Box 26.3.1.1 Main differential diagnosis of confusion

- Dementia
- Delirium (many causes including prescribed drugs, hypoglycaemia & hypoxia)
- Alcohol or drug intoxication or withdrawal
- Depression (depressive pseudo-dementia)

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Assessment History The history is the paramount investigation with confused patients (Box 26.3.1.2). For obvious reasons a collateral history is always needed—from family, primary care physician, care home staff, or simply from pre- vious medical notes. The observations of the patient’s behaviour by experienced ward staff may also be invaluable—especially in detecting fluctuation and inattentiveness. The first question is when the patient changed from their baseline mental state. A long history suggests an established dementia. The family or care staff may be aware of the diagnosis and/or the patient may have been prescribed antidementia medication. Patients with undiagnosed dementia often have a history of progressive short- term memory loss, disorientation in time, dysphasia, impairment of activities of daily living including instrumental activities (e.g. using phone/cooking/doing bills) and more basic activities (e.g. dressing/ toileting). There may also be a history of personality change such as a coarsening of manners or the development of apathy. Where the diagnosis is that of a new delirium there will either be little or no evidence of impairment in background cognition or daily activities, or a rapid deterioration from a well-established baseline level of impairment when the delirium is superimposed on a de- mentia. Collateral history will reveal a rapid onset of mental change characterized by vague, inattentive responses, periods of change- able alertness, forgetfulness, disorientation, muddled speech, and changes in mood. There may have been frank psychotic experiences including abnormal visual experiences or paranoid delusions. Key questions to ask are if there were signs of physical illness, a change in medication, or a change in physical location in the days leading to the new mental state.

Examination Appearance and behaviour The patient may be dishevelled or show self-neglect. There may be obvious clues to sources of confusion (e.g. a nonfunctional hearing aid, wheeziness/productive cough, or a Parkinsonian tremor sug- gesting Lewy body dementia). In delirium, patients may be aroused and alert, or sleepy. They may show

sustained attention during assessment (in dementia) or be unable to sustain attention (in delirium). Speech Patients with dementia are likely to show expressive dysphasia (difficulty with production of speech) or may fail to understand commands (receptive dysphasia). Patients with certain causes of confusion (e.g. Parkinson's disease) may show slurring of speech. Patients with depression may show retardation of speech with low volume answers which are considerably delayed. Mood Patients with acute confusion due to delirium are typically bewildered and may appear frightened. Patients with depression look sad or irritable, with a lack of expected emotional reactivity. Patients with dementia are usually normal in affect, though may become labile, agitated, or disinhibited as the condition advances. Thoughts Depressive ideas (e.g. depressive delusions of hopelessness, guilt, or nihilistic type) suggest a severe depressive disorder. Patients with delirium may report fractured paranoid ideas (e.g. of people planning to hurt them), but these are rarely sustained. Patients with dementia usually report normal thought content, though may confabulate (report plausible but untrue accounts of their recent experiences). Perceptions In dementia, hallucinations are rare except for dementia with Lewy bodies where visual hallucinations are common. Abnormal visual experiences are however common in delirium. Patients currently experiencing visual hallucinations will be seen attending to phenomena unseen by the observer. Mood congruent auditory hallucinations (e.g. voices commanding the patient to self-harm) are a rare but highly suggestive feature of severe depressive episodes. Cognition By definition, cognition is impaired in confused patients. Commonly used short assessments of cognition include the Abbreviated Mental Test Score (AMTS), which assesses cognition in about three minutes and is reasonably sensitive to change. On retesting, patients with delirium will usually show some fluctuation with improvement and deterioration, while patients with simple dementia will usually be stable between assessments. Patients with depression may score poorly, but will show a lack of effort, for example refusing to attempt tests of recall or of sustained attention like counting down. More detailed tests of cognition are useful in describing cross-sectional cognitive impairment, for example the Montreal Cognitive Assessment (MoCA), or the Addenbrooke's Cognitive Assessment-III (ACE-III). These require correction of extraneous influences such as a quiet space, fewer interruptions, and the use of visual and auditory aids. A brief attention test (e.g. counting down from 20 to 1) may help identify inattention due to delirium. Insight into their condition Insight is almost always absent in confused patients but this rarely discriminates causes. Patients with severe depression are likely to self-blame for their situation, while patients with dementia may make bland but frank denials of problems. Physical assessment The physical assessment of a patient presenting with confusion is often difficult and may need to be opportunistic. A period of observation may show a slumped patient unable to sustain posture, or they may be agitated and fidgety in the bed. Hands waving in the air, or picking at the sheets are specific signs seen in delirium (floccilation). If the patient is walking then observe the gait for signs of truncal

Box 26.3.1.2 Key points in the history of a patient presenting with confusion

- What is patient's baseline? (ADLs, cognition, personality)
- When did the change happen?
- Has any obvious factor led to this? (new drug/operation/change of dwelling)
- Has there been a change in alertness/attention span?
- Do they seem forgetful even when fully alert?

section 26 Psychiatric and drug-related disorders 6456 rigidity (stiffness), or frank Parkinsonism in vascular dementia or dementia with Lewy bodies. Physical signs are listed in Box 26.3.1.3. Temperature, blood pressure, heart rate, respiratory rate, and oxygen saturation should be done to investigate for infection, or systemic inflammatory response. This is often blunted in older people however. Blood tests for markers of infection (white cell count, C-reactive protein, or blood cultures) should be performed. Neurological examination Neurological examination should focus on

ophthalmoplegias, and focal neurological deficits such as unilateral limb weakness. These suggest the presence of stroke, subdural haematoma, or a Parkinson's plus syndrome. Signs of upper limb rigidity or cog-wheeling may be present in cerebrovascular disease or in dementia with Lewy bodies. CT brain imaging is rarely helpful in delirium, but should be done in the context of focal neurological signs, recent head injury, or use of oral anticoagulants. More detailed imaging with MRI, functional imaging, or cerebrospinal fluid examination may be indicated in cases where the diagnosis is unclear. Cardiovascular, respiratory, and abdominal examination These should focus on the assessment of potential sources of infection in the case of delirium. Abdominal examination should rule out peritonism and focus on the possibility of constipation. A rectal examination to look for faecal impaction may be appropriate. Chest and abdominal X-rays should be considered. Urinary system Urinary tract infection is overdiagnosed as a cause of delirium in older people and routine urine dipstick testing is usually of no value due to a low positive predictive value. Urinary incontinence may be found in normal pressure hydrocephalus. A palpable bladder from urinary retention should be excluded; bedside bladder scanning can help. Blood tests should include renal function and electrolytes. Musculoskeletal system Care should be taken to examine for injuries or joint inflammation as a cause of pain. Examine the hips to exclude fracture of the femoral neck and have a low threshold to x-ray the pelvis. Management The first priority in management is to keep the confused person safe. In hospital this usually requires a quiet side room and often special nursing attention. Sequential assessments are always necessary in confused patients. Rapid and potentially useful assessments include the Confusion Assessment Method (CAM) or a brief cognitive assessment like Abbreviated Mental Test (AMTS) or 4-AT. The CAM helps focus on the key clinical features of delirium—rapid onset, fluctuating course, inattention, disorganized thinking, and altered level of consciousness. For delirium an urgent and vigorous search for the cause is required. As well as common causes such as infection, cerebral ischaemia and cardiac ischaemia it is important not to forget the effect of prescribed medications and withdrawal from alcohol. Rapid resolution of symptoms makes delirium the most likely diagnosis, and no further action may be required. However if the patient remains persistently cognitively impaired, without fluctuation, in clear consciousness, then dementia must be strongly suspected. Referral on to a memory clinic is likely to be required, and done according to local protocols. A clinical picture dominated by agitation, psychomotor retardation, gloominess, poor oral intake and passive resistance to care will strongly suggest a severe depressive disorder and urgent referral to psychiatric services is needed. Conclusion Patients presenting with confusion in general hospitals are at high risk of having significant undiagnosed organic brain disorders, with up to half of all cases of dementia being undiagnosed. The rate of diagnosis could potentially be improved by systematic screening, though potential problems include the high mortality of patients who have been through the general hospital, and the high proportion of false positive cases who will be subject to stressful and negative investigations for dementia. Contrary to common belief, many cases of delirium do not resolve rapidly. Around 40% of general hospital cases of delirium are unresolved at discharge and up to 20% of cases are unresolved after six months. Finally, delirium is also a well-established risk factor for development of later dementia. FURTHER READING Inouye SK (2003). The Confusion Assessment Method (CAM): Training manual and coding guide. Yale University School of Medicine, New Haven, CT. Sampson E, et al. (2009). Dementia in the acute hospital: Prospective cohort study of prevalence and mortality. *Br J Psychiatry*, 195, 61–6. Cole MG (2010). Persistent delirium in older hospital inpatients. *Curr Opin Psychiatry*, 23, 250–4. Bellelli G, et al. (2014). Validation of the 4AT, a new instrument for rapid delirium screening: A study in 234 hospitalised older people. *Age Ageing*, 43, 496–502. Gross AL, et al. (2012). Delirium and long-term cognitive trajectory among persons with dementia. *Arch Int Med*, 172, 1324–31. Box

26.3.1.3 Common physical signs that are important not to miss in the confused patient • Urinary retention, constipation • Occult causes of pain • Has there been a recent fall or injury? • Are there signs of hip injury? • Neurological signs • Obvious ophthalmoplegia • Obvious hemiplegia • Physical signs of delirium • Typical hand movements (aimless plucking at bed clothes, also known as floccilation or tilmus) • Tremor, dysgraphia

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