NATIONAL CANCER GRID
COLLABORATION FOR CANCER CARE

NCG Palliative Care Guidelines – Delirium

Approach to managing Delirium [1 2 3 4 5 6 7]

- Existing Ayushman Bharat Package
- Palliative care package for Delirium

Cancer patient with acute and fluctuating features of cognition, inattention, disorganized thinking, illogical speech, levels of consciousness/ perception (hallucinations). Disoriented in time/space/person. Agitated or unusually quiet

Screen with RASS and Confusion Assessment Method (CAM) OR 4AT. Confirm diagnose using DSM 5 (not mandatory to initiate symptom control)- **Details: foot-note**

Are there predisposing factors? Screen regulrly in Frail, male, elderly, impaired sight/hearing, multiple-comorbidities, unfamiliar/ unnatural environment e.g. ICU / prolonged hospitalisation

History, examination& investigatons to determine reversible/ iatrogenic precipitators - CBC, CRP, sugar, Sodium, Potassium, Calcium, Magnesium; RFT, Urine C/S, XRay Chest & TFT if suspectd

Poor response, intractable, severe disress, aggression, agitation, self harm/ harm to others; severe psychotic symptoms, interfering with routine care

Simultaneous supportive care

Determine Hypokinetic, Hyperkinetic OR Mixed variety of delirium

New focal neurological signs, reduced level of consciousness, supected brain metastasis, history of falls, head injury, patient on anticoagulation therapy.

CT Scan/MRI - as per prognostication; and/or refer to RT, neurology, neurosurgery

Prevent OR correct contributing factors - Dehydration, control pain / other symptoms; treat sepsis, optimise bowel/ bladder dysfunction, dyselectrolytemia, metabolic drangements, hypoxia/hypercarbia, drugs, hypoglycemia, hypothyroid - Refer as appropriate to Internal medicine

Are the mental changes chronic? - consider dementia, depression.

Is there H/O alcohol/substance use

OR severe agitation/ aggressive behavior, self harm - despite initial therapy

Psychiatry reference and appropriate Ayu Bharat packages

•Other Iatrogenic factors identified and corrected E.g. use of physical restraints, nutritional/ fluid derangements, use of a bladder catheter, any iatrogenic event, use of 3 or more medications, use of delirium inducing high dose medications - opioids/ steroids/ sedatives/ anticholinergics/ antidepressants / neuroleptics

Treat the Delirium symptomatically

See next page

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[1] Confusion Assessment Method - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2585541/pdf/nihms50514.pdf.
[2] DSA 5- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. 5th ed. Washington,
[3] RASS Calculator: https://www.mdcalc.com/richmond-agitation-sedation-scale-rass
[4] 4Ats - https://static1.squarespace.com/static/543cac47e4b0388ca43554df/t/5f0592e7917a0733e509ea0b/1594200808505/4AT+v1_2+Oct+2014.pdf
[5] http://www.delirant.info/DreamHC/Download/MDAS.pdf
[6] Effect of anti-psychotics and non-pharmacotherapy - https://pubmed.ncbi.nlm.nih.gov/32730108/
[7] The Frequency, Characteristics, and Outcomes Among Cancer Patients With Delirium- https://pubmed.ncbi.nlm.nih.gov/26417036/

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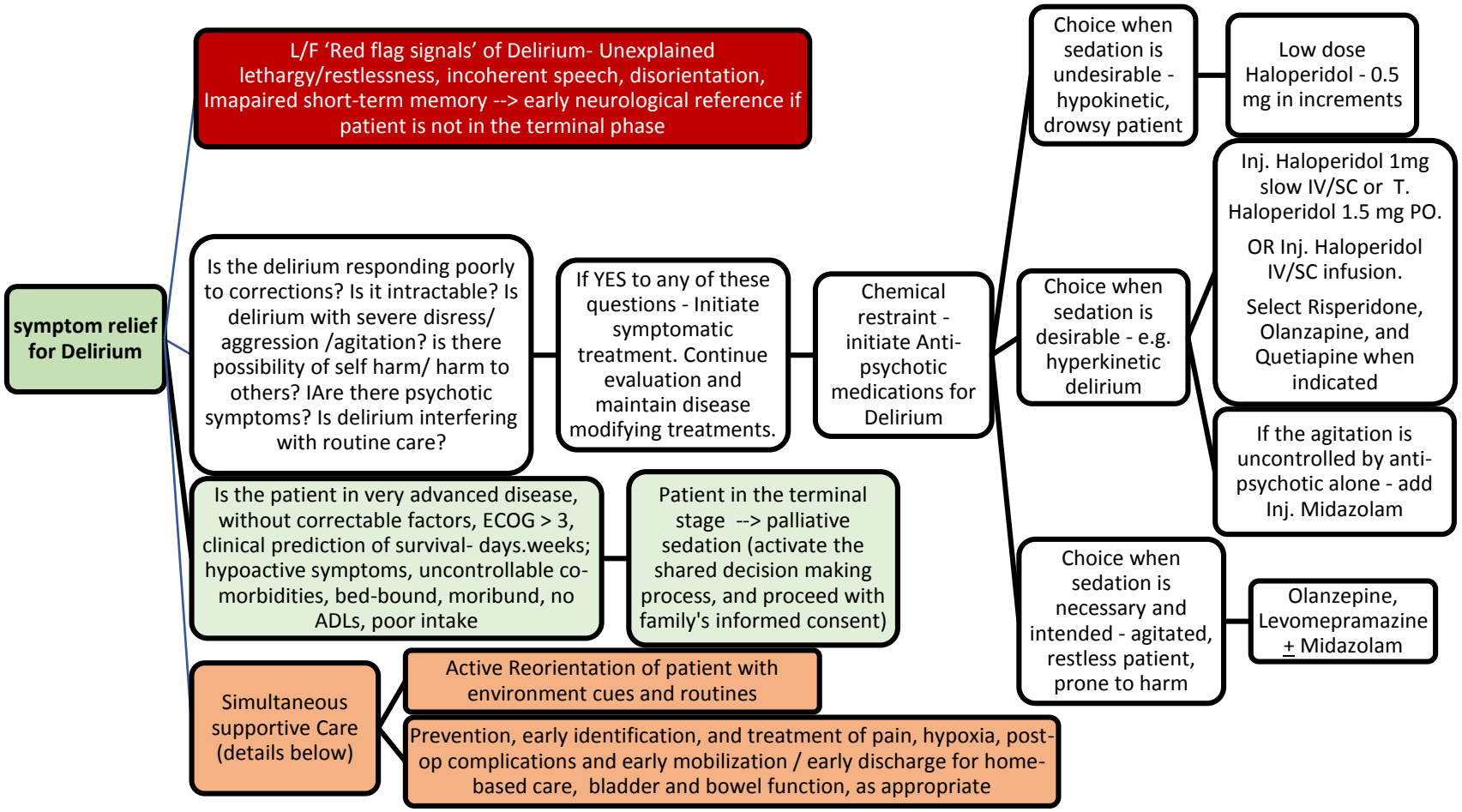

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Drugs used in Palliative Care Management of Delirium

TABLE A

Haloperidol – avoid in patients with dementia, Parkinsonism Availability : Tablets/Liquid/Injection Routes of administration: Oral/ Subcutaneous/Intravenous **Dose**: • Mild/ elderly - start with 0.5 mg with increments of 0.5 mg • Moderate- severe - start with Inj. Haloperidol 1.0 slow IV/SC as bolus followed by a continuous infusion of Haloperidol up to 15 mg/24 h or till reversal of symptoms • Max upto 15 -20 mg/24 h -based on response • Alternatively Haloperidol dose may be rotated every 4 hours with Chlorpromazine (equivalence: 1mg Haloperdol = 12.5 mg Chlorpromazine)	**Olanazapine:** It has a sedating effect Increased mortality seen in patients with dementia, Parkinsonism, renal/liver dysfunction. (alternative to Haloperidol, if there is history of extrapyramidal side effects to Haloperidol) Availability: Tablets (Oral and MD Tablets)/ Injection Route:Oral/Buccal/ Intramuscular (deep) **Dose**: start with 2.5 mg with increments of 2.5 mg Max upto 15-20 mg/24h
Risperidone: Sedative effect + Causes increased mortality in patients with dementia, Parkinsonism, renal/liver dysfunction Availability: oral tablets Routes: Oral Dose: start with 0.5 mg with increments of 0.5 mg Max upto 3.0-4.0 mg/24 hours	**Quetiapine:** Sedative effect + lowest incidence of Extra-pyramidal side effects Availability: tablets, mouth-dissolving Routes: oral Dose: start with 12.5 mg with increments of 12.5 mg Max upto 100 mg/24 hours
Special situations	
Agitation uncontrolled with anti-psychotic alone **Midazolam**: Titrated Midazolam as intermittent Subcutaneous/ Intravenous Injections for calming a **Hyperactive, delirius** patient **Dose**: Inj. Midazolam 1- 2 mg slow IV/SC and repeat 2 hourly till the patient becomes quiet; up to a maximum dose of 30 mg/24 h as continuous infusion (IV/SC) until the patient becomes calm. **Aim**: symptom control. Used as a chemical restraint (avoid physical restraints)	**Suspected raised ICT** **Dexamethasone** Availability: Tablets/Injections Routes of administration: Oral/Subcutaneous/Intravenous Dose: 16-24 mg/ 24 hours od. *May be given before oncology/ neurology consultation , if there is evidence of cerebral metastases. Continuation depends on oncology/ neurology opinion and symptom **improvement**

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Lorazepam (alternative if Midazolam is not available) Availability: Tablets/Injections Routes of administration: Oral/Sublingual/Intravenous Dose: 0.5 – 1mg every 2h Up to maximum dose of 10mg/day	**Additional drugs required for** correction of dyselectrolytemias **1.** Bisphosphonates **2.** Calcium gluconate **3.** Potassium binders **4.** Magnesium Sulphate

Monitor and optimise comorbidities – e.g. Hypertension, Diabetes, Asthma, others

Address Drug-induced etiollogy: Discontinue/modify Delirium -inducing medications – listed below

1. Anticholinergics (Benadryl, tricyclic antidepressants) 2. Narcotics (meperidine) 3. Sedative hypnotics (benzodiazepines)	4. Histamine-2 (H2) blockers (cimetidine) 5. Corticosteroids 6. Centrally acting antihypertensives (methyldopa, reserpine) 7. Anti-Parkinson drugs (levodopa)

Terminal Delirium with severe agitation - Palliative sedation may be needed (This is a shared decision – after empathetic communications with the family & only after documented informed consent – Review Guidelines for Palliative Sedation under the NCG Guidelines of End of Life Care)

- **1st line: Midazolam added to Haloperidol – as intermittent Subcutaneous/ Intravenous Injections – Titrate gradually to maximum dose of 20 mg / 24 hours – rarely up to 25- 30 mg/24h depending on control of agitation.**
- If ineffective – monitored infusion – S/C or IV - Phenobarbitone / Pentobarbitone /Propofol. Dose is titrated to symptom control.

TABLE B SUPPORTIVE CARE

Communication	MDT referrals	Supportive environment

Family meeting
• Respond to the family distress
• Educate:
  ○ regarding relation to the disease and physiological derangements
  ○ their role in improving the situation – Non-pharmacological inputs **(Refer to #)**
  ○ support the burden of decision making
  ○ Importance of nutrition and hydration & use of right medicines, timely
- Presence - with calm, patience and non-argumentative, non-challenging conversations
- Seek information, and advice on maintaining important connectedness aspects for the individual e.g. being at home in their familiar settings, maintaining daily routines
- Ensure effective coomunucation among the family members
	Dietician –**hydration,** Food supplements
	
	Physiotherapy – Improving ambulation
	
	Counseling – after the acute episode abates – facilitated dicscussions to address unresolved fears and anxieties
		• Reorientation techniques
		• Empathetic presence and support - Patients not to be left alone or unattended especially in evening hours
		• Natural light, moving patient to diferent bed / ward - closer to window to improve natural and diurnal cues
		• Mobilise, offer water, feeds intermittently
		• re-instate sensory aids - spectacles/Hearing aids / Walking aids/ Crutches/ wheel chair
		• Promote sleep /wake cycle, sleep hygiene-undisturbed at night
		• memory cues such as a calendar, clocks, and family photos.
		• A stable, quiet, and well-lighted environment.

Non-pharmacological inputs # - How may family/ friend/ caregiver help? Ref: https://www.rcpsych.ac.uk/mental-health/problems-disorders/delirium

• Stay calm, talk to them in short, simple sentences and check that they have understood you • repeat things if necessary • remind them of what is happening and how they are doing • remind them of the time and date – make sure they can see a clock or a calendar • listen to them and reassure them • offer and help them to eat and drink • make sure they have their glasses and hearing aid • if they are in hospital, bring in some familiar objects from home	• try to make sure that someone they know well, is with them – this is often most important during the evening, when confusion often gets worse • have a light on at night so that they can see where they are if they wake up. • After recovery – the patient may remember the emotions you felt at the time, and this can be unpleasant and frightening. It can be helpful to sit down with someone who can explain what happened (a family member, a friend, or nurse/doctor). Most people feel relieved when they understand what happened and why.

TABLE C - NURSING PROCEDURES and EQUIPMENTS

Procedures
1. **Regular assessment of Delirium, Pain, Fever, feeds, bowel movements, Maintaining input-output chart**

2. **Administration of drugs - (Oral/Injections – SC/IV)**
3. **Insertion of NGT and checking feeding schedules - NGT- Nasogastric tubes (Adult), Gloves, 2% Lignocaine gel**
4. **Bowel:** Constipation – **Review the NCG Guidelines for Constipation** (Insertion of suppository - Gloves , KY jelly,Bisacodyl (Adult); high-up enema as required)
5. **Bladder:** Catheter insertion/change- Sterile gloves/Nelaton's catheters (Adult), Foleys /Silicone catheters (Adult)/ 2%Lignocaine gel, Sodium phosphate enema)
6. **Care for pressure points:** **Review the NCG Guidelines for Pressure Ulcer on the NCG Website**

References: Shirley Harvey Bush et.al. **Clinical Assessment and Management of Delirium in the Palliative Care Setting;** Drugs (2017) 77:1623–1643