

PALLIATIVE CARE TIPS

Issue # 15 Depression or Delirium?

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Delirium is characterized by the acute onset of disordered attention (arousal) and cognition, accompanied by disturbances of psychomotor behaviour and perception. Up to 80% of terminal cancer patients will develop delirium in the last week of life.

Three clinical variants of delirium have been described based on the type of arousal disturbance-

Hyperactive - hyperalert: confusion + agitation +/- hallucinations +/- myoclonus +/- hyperalgesia

Hypoactive - hypoalert: confusion + somnolence +/- ↓ alertness (withdrawn)

Mixed: features of both above.

The prevalence of **Depression** in cancer patients ranges from 13-25%. In cancer patients, somatic symptoms such as anorexia, fatigue, weight loss, and insomnia are of limited value as diagnostic criteria for depression since many of these symptoms exist as a consequence of advanced cancer.

Psychological symptoms have been found to be more useful in the diagnosis of depression in cancer patients. These symptoms may include a depressed mood, feelings of worthlessness, guilt, hopelessness, anhedonia, and the presence of suicidal ideation (thoughts of death).

NB** Delirium, particularly early delirium and/or the hypoactive form, may be misdiagnosed as depression. These delirious patients may exhibit a decreased level of alertness or appear withdrawn, mimicking features of depression. In these cases, inappropriate treatment with antidepressants may occur.

Key Points:

1. Delirium is more common than depression in advanced cancer patients.
2. Early and/or hypoactive delirium can be misdiagnosed as depression resulting in inappropriate treatment.
3. Misdiagnosis of depression for delirium can be decreased if a high degree of suspicion is maintained. Mental Status Exam (MMSE)* and the Confusion Assessment Method (CAM)** are two well-validated yet suitably brief instruments that have been widely used in a screening of delirium. The CAM is rated on the basis of physician or nurse interaction with the patient, and assesses the presence or absence of four criteria: acute onset and fluctuating course; inattention; disorganized thinking; altered level of consciousness. These tools should be administered to patients on a regular basis.. Similarly, the use of screening tools for depression such as the Beck depression inventory (BDI) or the Hospital Anxiety and Depression Scale (HADS) could be considered.

*Used by the Edmonton Palliative Care Program.

** Inouye SK, van Dyck, CH, Alessi CA, et al. Clarifying confusion: the confusion assessment method. A new method for detection of delirium. Ann Intern Med 1999;113:941-8.

REMEMBER: For referrals, questions, or telephone consultations call 496-1300 weekdays and weekends.

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