OASIS Alert

Training: SET YOUR SIGHTS ON THESE DELIRIUM-INDUCING DRUGS

Train clinicians to consult this list to stay ahead of the curve.

Know the best way to prevent delirium? Keeping patients off the medications known to cause people to become delirious. Unfortunately, that's not always possible.

Better: Train your clinicians to look for these key strategies for detecting and treating delirium when medications are involved.

1. Determine whether the patient has developed medication-related delirium in the past, advises **William Simonson**, a pharmacology consultant in Suffolk, Va. "If so, it's likely to occur again," he warns.

Example: In one case, a patient became very delirious when treated with an antibiotic. Clinicians initially attributed the delirium to his infection, but his symptoms escalated after the UTI symptoms began to resolve.

When asked, the patient's wife told staff that the patient had become "out of his mind" twice before when treated with the same antibiotic, he says.

2. Flag any high-risk meds. Certain medications, such as those with anticholinergic properties, pose a higher risk for causing delirium, notes Simonson. Patients may be on "several medications that have anticholinergic properties," including those used to treat urinary incontinence and OTC sleep aids.

Bigger list: Anticholinergic medications aren't the only medications known to cause delirium. Add to that list benzodiazepines and sleep medications, such as zolpidem, says **Darren M. Triller**, director of pharmacy services for **IPRO** in New York. "Some of the antiseizure drugs used for neuropathic pain can also cause delirium," Triller adds.

Other medications known to cause delirium include anti-Parkinson's medications; H2 blockers, such as cimetidine, antiemetics, antihistamines, opioids, tricyclics; some blood pressure medications; antipsychotics; and muscle relaxants, according to The Merck Manual of Health & Aging.

3. Consider the "anticholinergic load" when adding a medication. Pharmacists often rank drugs as "being high, medium, or low in terms of their anticholinergic properties," says Triller. "That way you can eyeball the patient's medications and assign a score."

Examples: A person may have been on an anticholinergic for bladder incontinence for some time, says Triller. But due to a recent cold and insomnia, the person "is now also taking a cold preparation that has an anticholinergic in it, and Tylenol PM, a product containing the anticholinergic diphenhydramine for sleep," adds Triller. This increased load is a warning sign to be on the watch for delirium.

Different doses of the same drug can have a similar effect, Simonson points out. A person may be able to tolerate 10 mg of amitryptline for neuropathic pain whereas he'd be at higher risk for developing delirium when taking 50 to 100 mg of that same medication for depression, cautions Simonson.

Next step: Coach your clinicians to be on the lookout for these delirium-likely medications.

As soon as a patient that meets these criteria begins developing symptoms of delirium or dementia, instruct workers to immediately consult the primary physician and other caregivers.

Early detection can keep serious consequences at bay.

Resources: View an extensive list of medications associated with delirium and dementia at www.merck.com/pubs/mmanual_ha/tables/tb26_1.html.