

Guideline: Care of Confused and Aggressive Patients

(Some of these features are present in terminal agitation, see the Integrated Care of the Dying Pathway)

Confusion is common in patients with advanced cancer. Up to 20% of hospitalised cancer patients have organic mental disorders. More than 75% of terminally ill cancer patients become confused at some stage. Aggression may be a feature of confusion in any patient, however out of character. It may also be encountered in distressed carers and relatives, particularly when exposed to alcohol.

Clinical Causes Of Confusion

Note:

- Most cases of confusion are multi-factorial
- In about 50% of cases, the cause remains undefined.

Metabolic causes:

- Infection
- Dehydration
- Polypharmacy – especially opioids and anticholinergics
- Alcohol withdrawal
- Drug withdrawal
- Biochemical disturbance
- Hypoxia
- Hypercapnia
- Pain fatigue
- Hypoglycaemia
- Vitamin deficiency

Physical:

- Pain
- Fatigue
- Trauma
- Cerebrovascular accident

End stage:

- Organ failure
- Cancer

Psychological Triggers For Aggression

- Fear
- Frustration
- Humiliation
- Inappropriate assertiveness
- Vulnerability
- Threats (self defence)
- Feeling of oppression.

General Care To Reduce Confusion

Communication:

Explanation is important:

- Calmly explain everything to the patient, family and carers.

Environment:

The environment needs to be quiet and reassuring, with:

- Subdued lighting
- Familiar faces
- A small number of (familiar) staff involved in care
- Safety

Use Of Medication In Confused And Aggressive Patients

Iatrogenic problems:

Always check that drugs are not the major cause of cognitive dysfunction. Recent prescription of opiates, antidepressants, anticholinergics etc. may be implicated, especially in a patient with co-existing metabolic derangements.

Choice of psychotropic drugs:

HALOPERIDOL is the drug of choice in palliative care. It has less cardiovascular side effects. It has a long half life, and gives smooth effective antipsychotic control for a sustained period. It can be given orally or subcutaneously. For rapid onset of action, high dose intravenous medication gives immediate effective plasma levels.

LEVOMEPRMAZINE Has a broadly similar use to haloperidol, however is more sedative.

BENZODIAZEPINE DRUGS reduce the element of anxiety and panic which often accompanies confusion and agitation. However, they have no antipsychotic effect, and may even precipitate heightened aggression and agitation in an already confused patient because of the disinhibiting effect. For this reason, benzodiazepines should not be used in a psychotic patient without the addition of haloperidol. The rapid onset of sedation with SC midazolam is sometimes a helpful adjunct to the use of SC/IV haloperidol in controlling a highly agitated patient.

POINTS TO NOTE:

- In patients with psychotic features only haloperidol should be used.
- Midazolam has a theoretical advantage in that it doesn't decrease the seizure threshold.

Recommended regimes:

HALOPERIDOL 3mg to 6mg orally

HALOPERIDOL 5mg SC, repeated up to 30mg per 24 hours

HALOPERIDOL 5-10mg SC supplemented by

MIDAZOLAM 5mg SC for rapid sedation (repeated within one hour if ineffective)

Prophylaxis:

Wherever possible, distress should be anticipated by careful team assessment. Early intervention with low dose psychotropic drugs on a regular basis will prevent a potentially dangerous and distressing emergency. Signs of developing confusion, paranoia or aggression should be reviewed on a daily basis, with dose adjustments as necessary.

Recommended regime: **HALOPERIDOL 3mg – 6mg orally/SC in the evening or at night**

Side effects of antipsychotics:

Typical antipsychotics (haloperidol and levomepromazine) have more extrapyramidal side effects than atypical **antipsychotics** (olanzapine and risperidone).

Haloperidol is nevertheless the drug of first choice in palliative medicine because of its flexibility. It has less cardiovascular side effects than the phenothiazines. It is available in parenteral form. Common side effects:

extrapyramidal effects (especially acute dystonia, akathisia), hypothermia, sedation, hypotension, endocrine effects, blood disorders, alterations in liver function, neuroleptic malignant syndrome. Haloperidol has no antimuscarinic effects.

Levomepromazine (methotrimeprazine, *Nozinan*) is a useful alternative because of its analgesic effect and greater anti-emetic effect. Its combined profile can be useful in the terminal stage when a higher level of sedation is acceptable. Common side effects: sedation (particularly with doses >25mg/24hr), dose-dependent postural hypotension, antimuscarinic effects.

Olanzapine and **risperidone** are atypical antipsychotics which have also been used in palliative care because of their better side-effect profile. They are not available in parenteral form, so are less useful for the management of acute agitation and not useful for the treatment of behavioural features.