Acute Pharmacological Management Guideline – for Older Inpatients

**DE L I R I U M**

Not alcohol withdrawal

1. Optimise non-pharmacological management.
2. Use medication for distressing symptoms (eg highly agitated or hallucinating)

If resistant to non-pharmacological treatment

3. Haloperidol
   - **Orally**
   - 0.5mg (up to 1mg)
   - If needed repeat in 2-4 hours
   - Maximum 4mg/24hours
   - **IM (not IV) - only if oral access not possible**
   - 0.25 – 0.5mg
   - NB 30-60 minute onset and is minimally sedating

4. Proceed to next step if first line pharmacologic therapy is associated with unacceptable toxicity or ineffective

5. Prominent psychotic features
   - Risperidone
     - Quicklet, tablet, solution
     - 0.25 – 0.5mg start dose
     - If needed repeat in 2-4 hours
     - Maximum 4mg/24hours
   - OR
   - Olanzapine
     - Tablets, wafer, IM
     - 2.5mg
     - If needed repeat in 4 hours
     - Maximum 10mg/24 hours

5. Prominent agitation
   - Add Lorazepam
     - 0.5 - 1mg to start
     - If needed repeat in 4 hours
     - Maximum 3mg/24 hours
   - OR
   - Midazolam IM
     - 1mg
     - Once-off then change to oral lorazepam

6. Prominent agitation

**Antipsychotic agents**

- Rarely cause acute extrapyramidal side effects such as laryngeal dystonia, acute dystonias, oculogyric crisis. This requires urgent anticholinergic treatment (benztropine 1-2mg orally or IM)
- Watch for Neuroleptic Malignant Syndrome – consider if 2 hours of raised temp, raised CK, increased muscle tone or autonomic disturbance
- Check ECG for QT prolongation
- Atypical anti-psychotics may increase stroke risk in the elderly. They can cause sedation and postural hypotension as well as metabolic side effects (eg weight gain).
- Olanzapine is a second line alternative, but has the highest anticholinergic effects and can worsen

**Benzodiazepines**

- In general avoid benzodiazepine use as it prolongs delirium symptoms
- May cause paroxysmal excitation, respiratory depression or oversedation

1. Aim to use one drug and optimise first line treatment
2. Keep doses to a minimum
3. Avoid escalating doses
4. Seek advice
5. Review prescription daily

This guideline is endorsed by the RPH Drug sub-committee to assist in the acute management of older inpatients with delirium at Royal Perth Hospital

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