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# HOSPICE & PALLIATIVE CARE PERSPECTIVES

A PUBLICATION FOR PHYSICIANS AND MEDICAL STAFF



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## We welcome your input, questions and feedback

If you would like more information, please contact Dr. David Allen, Hospice of Larimer County Executive Medical Director, at (970) 663-3500.

## Our Mission

*Honoring every moment of life, Hospice of Larimer County provides compassionate, excellent, comprehensive care those who have an advanced medical condition and support to those who are grieving.*

## Our Values

*We honor life through:*  
Compassion  
Respect  
Integrity  
Excellence  
Stewardship



**Dr. David Allen**

Executive Medical Director,  
Hospice of Larimer County and Windsor Offices  
*Hospice and Palliative Care Certified*

## THE MEDICAL PERSPECTIVE:

### TERMINAL DELIRIUM

Delirium is an acute disturbance of attention, perception, thinking, and awareness which occurs in up to 33% of hospitalized patients and over 75% of those at the end of life.

The DSM-IV list four criteria for diagnosing delirium:

- Inattention
- Change in cognition
- Acute and fluctuating course
- Presence of medical etiology(ies)

There are at least three subtypes of terminal delirium. The hyperactive subtype presents as a flailing, yelling, agitated patient. The hypoactive subtype typically presents as a lethargic and confused patient. Finally there is a mixed group that may alternate between hyperactive and hypoactive.

Delirium may be confused with dementia, depression, grief, primary anxiety disorders, and psychotic illnesses.

The pathophysiology of delirium is not fully understood. The current hypothesis suggests a role for cholinergic deficiency, dopaminergic excess, inflammation and chronic stress brought on by illness or trauma.

The causes of delirium are many and can be recalled using the mnemonic:

- D** — drugs (opioids, benzodiazapines, antihistamines, anticholinergics)
- E** — electrolytes, glucose, dehydration
- L** — liver failure
- I** — ischemia, hypoxia, CO2 retention
- R** — renal failure
- I** — impaction
- U** — urinary infection or retention
- M** — metastases to the brain

Prevention of delirium should be a standard procedure in acute and chronic care settings for at risk patients. Studies have demonstrated the effectiveness of several interventions. Orientation and therapeutic activities for cognitive impairment, early mobilization, minimize drug use, prevent sleep deprivation, frequent communication, adaptive equipment

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## **Terminal Delirium**—Continued from page 1

(particularly hearing aids, and glasses), adequate hydration and nutrition. Unfortunately only 20% of patients with true terminal delirium can be managed with these approaches.

If reversible causes have been treated and symptoms remain a major issue one must consider the less than ideal pharmacologic options available. These include:

- Benzodiazepines with caution about disinhibition syndromes or paradoxical reactions
- Antipsychotics haloperidol, risperidone, olanzapine, quetiapine, ziprasidone and aripiprazole with caution about extrapyramidal side effects, weight gain, hyperglycemia, increased cardiac morbidity.
- Other options may include: divalproex, carbamazepine, gabapentin, SSRIs, SNRIs, cholinesterase inhibitors, mirtazapine, barbiturates and midazolam.

### **SELECTED REFERENCES:**

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—David Allen, Executive Medical Director

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## **A CHAPLAIN'S PERSPECTIVE: SPIRITUAL TERMINAL AGITATION**

Sometimes agitation demonstrated by people near the end of their life is spiritual in nature. This type of distress can be a major contributor to what looks like physical pain. As physical symptoms are being addressed, team members should always look for signs of spiritual distress that may be contributing to the pain observed. What are some signs that a person may have spiritual struggles? Here are a few: crying out and expressing terror with religious language (viz. using God's name); expressing the need to be alone with someone (either to confess some guilt or reconcile with that person); trying to accomplish one more task to be at peace with the purpose of their life; dwelling on regrets and anguishing over meaninglessness; anger and hostility toward people; etc. When these symptoms are manifested, the person's religious or spiritual leader (or Chaplain) should be called in to further assess what is causing the distress. Someone who knows the person well should help the spiritual caregiver determine what would be most helpful to bring spiritual peace.

One example of spiritual terminal agitation is a man who was very close to the end of his life and fighting death with everything he had in him. He had developed a relationship with me as his chaplain and I knew he had a background with the Catholic Church, but no longer was connected with that religious institution. The RN on the team called me near the end of the day and told me that she, along with his doctor, had done everything they could to treat the physical agony he demonstrated. She recognized that his struggles were beyond the physical and were likely spiritual in nature. So, she asked me to see him right away. I went in and he immediately brought up matters of guilt that were not resolved. I was asked to be his "priest" in a process of forgiveness and this brought him the peace he was seeking. That very evening, he rested from his turmoil and was able to pass away peacefully.

As you can see from this example, the spiritual part of a person can be a major contributor to end-of-life restlessness. It is one factor that needs to be assessed by the person's family along with others who are seeking a peaceful passing for their loved one.

—Dale Piers, Chaplain

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## **A COUNSELOR'S PERSPECTIVE: TERMINAL DELIRIUM—SUPPORTING THE PATIENT'S FAMILY**

The expressions of terminal delirium can be distressful for the family and friends, as well as for care providers. Social Workers and Chaplains, and all team members, should provide education and support to help the patient's family understand these changes along with the physical signs of impending death.

Although patients cannot report to us, it is thought that their experience is not as upsetting to them as to the people who observe them. The confusion, disorientation, agitation and restlessness, cognitive and perceptual disturbances *appear* to be unpleasant and may be perceived by others as suffering.

Family members may interpret hallucinations as disinhibited expression of the dying person's feelings and may attach a personal, hurtful meaning to them. Difficulties in bereavement may occur when a person's last memories of the loved one are veiled in hurt or perceived suffering.

Good comfort care requires that care providers involve the family early, at the first signs of changes in mentation.

We need to encourage the family that it is time to say the things they want to say while their loved one has the lucidity to have a meaningful goodbye.

It is important to normalize what is happening, to educate the family about the changes that are occurring and to let them know these changes are common in people just before death.

We can teach the family that hallucinations are not personal, or meaningful; that they are not expressions of the person's reality. We need to support their feelings and help minimize any potentially hurtful impact on family and friends.

We can encourage the family to maintain a familiar environment, which may include limiting visitors to those with whom the patient is familiar, avoiding new experiences as much as possible, and helping the patient stay oriented to time and place.

Most patients and their family members hope for a peaceful, comfortable death. We move toward this goal by providing education about terminal delirium and support for the family while we give medical, emotional and spiritual comfort care to the patient.

—Lani Hickman, Social Worker



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