

A Patient with an Altered Mental Status

Your first week on the medical service, you are asked to assume the care of an 88-year-old man who was recently admitted for a bleeding gastric ulcer. He was a resident of a nearby nursing home and has a long history of multiple medical problems including congestive heart failure, insulin dependent diabetes, chronic osteoarthritis, COPD with exacerbations of acute bronchitis, cerebrovascular disease (he sustained a mild thrombotic left hemispheric stroke 5 years ago), dementia, Parkinson's disease, and depression.

He underwent endoscopy the day after admission, he had his ulcer lasered locally to stop the bleeding, and he was transfused two units of PRBC to restore his hematocrit to 32%. You are called by the nursing staff because family members noted that he has had the new onset of confusion and somnolence that have fluctuated throughout the day.

His medications include Lasix, Lisinopril, Digoxin, Insulin, Prednisone (20 mg/day), Sinemet, Haldol, and Effexor.

P.E. reveals a thin elderly man who is awake but minimally responsive to questioning or stimuli. T 100.2; P 120 irreg irreg; R 16; BP 170/82. SKIN - dry with decreased turgor but no rash or lesions. LN - none palp. HEENT- conj normal; bilateral cataracts prevent fundoscopy; oropharynx has dry mucosa but no erythema; he wears bilateral hearing aids. CHEST - clear. COR - JVP 5 cm. Irreg irreg with variable S1 intensity, loud S2, no murmurs or rubs. ABD - soft; no masses or hepatosplenomegaly. G/R - normal; heme neg; a Foley bladder catheter is in place. EXT - no edema. NEURO - minimally responsive to questions and stimulation; cannot cooperate with cranial nerve, motor, cerebellar exam; reflexes are diminished throughout; Babinski signs are negative.

LABS: Na 149, K 5.0, Cl 109, HCO₃ 29, Cr 1.6, glu 355
Hb 11.0, Hct 31.5, WBC 9.2 (normal differential), plts 255K
UA: clear; 1.020; 1+ RBC, 2+ WBC; no casts
EKG: Irreg irreg about 120/min; QRS and QT intervals are nl
no ST-T wave changes noted
CXR (AP only): nl heart size/loss of diaphragm shadow behind the heart on the left side.

QUESTIONS:

1. Does this patient have delirium? What bedside features support this diagnosis?
2. What aspects of this patient predispose him to delirium?

3. What are potential precipitating causes of delirium exist for this patient?

4. Are there additional diagnostic tests you would order at this time?

5. On the day of admission, the patient's family asks you not to institute any "heroic" measures if the patient stops breathing or if his heart stops beating. They indicate that he "has suffered enough" and that he is no longer competent to make decisions about his medical care. How do you respond?

6. Assuming that your management is successful, what measures can you recommend to diminish the likelihood that this scenario will recur?