A case review

In preventing delirium in the wake of PTSD
Direct personal experience
Witnessed
Learned

The person's response to the event must involve intense fear, helplessness, or horror
Post Traumatic Stress Disorder

- Acute Stress Disorder
- Acute PTSD
- Chronic PTSD
- PTSD with Delayed Onset
<table>
<thead>
<tr>
<th>Physical</th>
<th>Cognitive/Mental</th>
<th>Emotional</th>
<th>Behavioral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest pain</td>
<td>Blaming someone</td>
<td>Agritation</td>
<td>Alcohol consumption</td>
</tr>
<tr>
<td>Chills</td>
<td>Change in alertness</td>
<td>Anxiety</td>
<td>Antisocial acts</td>
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<tr>
<td>Difficulty breathing</td>
<td>Confusion</td>
<td>Apprehension</td>
<td>Change in activity</td>
</tr>
<tr>
<td>Dizziness</td>
<td>Difficulty identifying familiar objects or people</td>
<td>Depression</td>
<td>Change in communication</td>
</tr>
<tr>
<td>Elevated blood pressure</td>
<td>Hyper-vigilance</td>
<td>Emotional shock</td>
<td>Change in sexual functioning</td>
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<tr>
<td>Fainting</td>
<td>Increased or decreased awareness of surroundings</td>
<td>Fear</td>
<td>Change in speech pattern</td>
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<td>Fatigue</td>
<td>Intrusive images</td>
<td>Feeling overwhelmed</td>
<td>Emotional outbursts</td>
</tr>
<tr>
<td>Grinding teeth</td>
<td>Loss of orientation to time, place, person</td>
<td>Grief</td>
<td>Erratic movements</td>
</tr>
<tr>
<td>Headaches</td>
<td>Memory problems</td>
<td>Guilt</td>
<td>Hyper-alert to environment</td>
</tr>
<tr>
<td>Muscle tremors</td>
<td>Nightmares</td>
<td>Inappropriate emotional response</td>
<td>Inability to rest</td>
</tr>
<tr>
<td>Nausea</td>
<td>Poor abstract thinking</td>
<td>Irritability</td>
<td>Loss or increased appetite</td>
</tr>
<tr>
<td>Profuse sweating</td>
<td>Poor attention</td>
<td>Loss of emotional control</td>
<td>Pacing</td>
</tr>
<tr>
<td>Rapid heart rate</td>
<td>Poor concentration</td>
<td>Severe pain</td>
<td>Somatic complaints</td>
</tr>
<tr>
<td>Shock symptoms</td>
<td>Poor decisions</td>
<td>Uncertainty</td>
<td>Startle reflex intensified</td>
</tr>
<tr>
<td>Thirst</td>
<td>Poor problem solving</td>
<td></td>
<td>Suspiciousness</td>
</tr>
<tr>
<td>Twitches</td>
<td></td>
<td></td>
<td>Withdrawal</td>
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<tr>
<td>Visual difficulties</td>
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<tr>
<td>Vomiting</td>
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<td>Weakness</td>
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Persistent Re-experience of the event
Persistent Avoidance
Persistent Increase in states of arousal

Causes significant distress and impairment in social, occupational, or other important areas of functioning
Complex chronic PTSD

- associated with sustained or repeated trauma during childhood or adolescence
- associated with sustained trauma in later life
- consequence of chronic PTSD

- persistent difficulties in interpersonal relations, mood, somatization
- profound identity problems
- comorbid disorders
2010 OHSU Trauma Report

- 67% Male
- Largest age range between 25-64 y.o.
- Increasing population >65 y.o. between 2008 and 2010

What about the baby boomers?

Women and children??

Pre existing cognitive and psychiatric condition

Rollover MVC
5/3/2011
Arrived alert in the ED
Emergently intubated
To the OR
Sedated on versed and fentanyl drips x 5 days

18 ventilator days

9 days until home SSI restarted

No definitive medical dx of delirium or psych consult

Inconsistent incorporation of delirium into nursing POC and handoff

Varying use of CAM and MAAS
The results

12 days of documented DELIRIUM
Early identification of patients with pre-existing PTSD as delirium risks and pass that information along to colleagues

Continuous evaluation: CAM q4 hours
  - Be aware of hypoactive subtype

Prepare patients with a history of PTSD for stressful medical procedures

Look for additional causes: labs, infection, meds

Use environmental methods proven to help in management
  - Glasses and hearing aid on, minimal restraints and tethering, early mobilization, calm setting

Consider geriatric or psych consultant
Good pain control with adjuncts

- Limit narcotics
- Tylenol, gabapentin, local anesthetics

Avoid use of benzodiazepines—especially infusions

- Alpha 2 blockers: precedex or clonidine
- Low dose haldol

Avoid anti-cholinergics

- Benadryl, scopolamine,
Asks the following questions for each patient:

1) Where is the patient going?
2) Where is the patient currently?
3) How did the patient get to their present state?

These questions can then be answered with 4 simple indicators:

- **Target the RASS.** Where is the patient going?
- **Determine the actual RASS.** Where is the patient now?
- **Determine the CAM-ICU.** Where is the patient in thought content now?
- **Assess the current drugs.** How did the patient get to his or her present state?...
- Create new plan of action
Understand that threat to life can mimic the original trauma, and exacerbate previously mild symptoms

Potential Triggers for PTSD/Anxiety
- Touching, Entering room unannounced, Ordering them what to do rather than providing options, Decreased functional capacity, Helplessness, Fear and Anxiety

Confusing a flashback for agitated delirium by provider
- Flashbacks tend to be more short-lived than episodes of delirium. Delirium can be related to PTSD and flashbacks.

Anticipate that they might UNDER REPORT
- physical/emotional pain and fear

Distrust in authority can lead to excessive questioning of providers' actions and refusal of care
Thank You