

Testimonial Dr. Thomas Ottens Anaesthesiologist-intensivist Haga Hospital, The Hague

In the intensive care unit, we often encounter delirium. That is due to the type of patients we treat. People in the IC unit have a greater than average chance of developing delirium. They are very ill patients who often have cardiac failure or sepsis or have undergone major surgery. These are all risk factors for developing delirium. Other risk factors in the ICU include the type of treatments the patients receive there, like artificial respiration and sedation.

The problem we are confronted with in the ICU is that delirium is notoriously difficult to diagnose. This is especially the case with the hypo-active variant, when patients show few visible signs or symptoms that can be observed by ICU personnel. Recently, in a delirium study conducted in our own ICU, we encountered a number of patients who seemed to be normally conscious when admitted, but afterwards proved to have had nightmares and hallucinations and did not remember their time in the ICU at all.

So it is obvious that even in a unit with a sound delirium protocol and active monitoring with proactive checklists like the ICDSC, the Intensive Care Delirium Screening Checklist, patients still fall through the net. Time and again patients with a hypo-active delirium remain under our radar. We simply miss them no matter how intensely we focus on recognising and identifying delirium. That is very annoying for this patient group in particular because they can suffer for a long time from delirium. Not only during admission, but for years afterwards. During contact with patients in follow-up interviews, it has repeatedly become evident just how terrifying and unpleasant delirium is for the patient. So unpleasant that the effects can persist in someone's life for years afterwards.

That is why early detection is so important. We have few effective tools to shorten the duration of delirium, but we can actively alleviate the patient's suffering in a rather simple way. You can help patients by reassuring them and helping them to orient themselves, continue to explain that they are in the hospital, keep telling them what is going on.



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We can also choose a medical treatment for the anxiety symptoms or hallucinations. Early detection is also important for a good after-care. You can offer patients the right follow-up immediately after discharge by helping them through the process, and this provides the opportunity to recognise people who need additional help like psychological support with PTSD or rehabilitation for cognitive disorders.

Regardless, many clinicians only start taking action when the symptoms of delirium are evident, although simple monitoring methods are available that could be implemented routinely for all patients. In my opinion, not screening for delirium is as strange as not measuring the blood pressure, temperature or saturation. That's something you do several times a day, isn't it? Then why not include delirium? The consequences are so radical for the patient that you must do something as a doctor. You can't just ignore it.

That is why I want to take a stand for a national delta plan for delirium monitoring in all ICUs in the Netherlands. We need to change our thinking about this. We must consider delirium as a red flag. Alarm bells should go off if you suspect delirium, because the consequences for missing delirium are so major for the patient. Yes, there will still always be episodes, but that doesn't mean you shouldn't make every effort to detect delirium as early as possible. I am convinced that implementing routine delirium screening is feasible for every ICU in the Netherlands. Because of our responsibility towards the patient, we must do everything we can to minimise the consequences of delirium.

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