Compass SHARP in Practice Podcast Series

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COMPASS HEALTHCARE COLLABORATIVE
Sustainable Healthcare Transformation

Postoperative Delirium: Part 2

Hosted By: Donald Stader, MD, FACEP, FASAM, with guest Dr. Jennifer Hah, MD (anesthesiologist, pain, and addiction medicine specialist)

Q&A Highlights

Q: Are there medications that increase the risk of delirium?
A: In addition to benzodiazepines and gabapentinoids, medications that can increase delirium risk include tricyclic antidepressants, certain antihistamines (like diphenhydramine/Benadryl), and scopolamine. If these drugs must be used, lower doses and shorter courses are recommended.

Q: How can surgical teams prevent delirium?
A: Focus on non-pharmacologic strategies: reorient patients, maintain sleep-wake cycles, provide cues for time and day, involve family, ensure glasses/hearing aids are used, optimize early mobilization, incorporate behavioral strategies like diaphragmatic breathing, and maintain nutrition. After optimizing these, consider melatonin or ramelteon to support sleep.

Q: What does delirium look like clinically?
A: It presents acutely with fluctuating symptoms. A patient may appear alert in the morning but become confused, tangential, or agitated in the evenings. Delirium can also be hypoactive, with lethargy or reduced responsiveness, which is harder to detect.

Q: When does delirium usually occur after surgery?
A: Typically within 1–5 days post-op, often around 2–3 days. Rapid transitions from anesthesia, medication changes, or metabolic shifts can precipitate it.

Q: How is delirium diagnosed?
A: Diagnosis is clinical and can be guided by the Confusion Assessment Method, which looks for: acute onset and fluctuating course, inattention, and either disorganized thinking or altered level of consciousness.

Q: Are there challenges in recognizing delirium?
A: Yes, especially hypoactive delirium. Patients may seem fatigued or quieter than expected, which can be misinterpreted as normal post-op recovery.

Q: How is delirium treated once identified?
A: Start with non-pharmacologic strategies and reorientation. Review pain management and multimodal regimens, check for metabolic issues, infection, dehydration, constipation, or urinary retention. Pharmacologic treatment is limited; antipsychotics like olanzapine may be used for severe agitation, but benzodiazepines are generally avoided.

Q: What are the long-term implications of delirium?
A: Delirium is an independent risk factor for long-term cognitive decline, regardless of preoperative cognitive status. Preventing delirium, identifying underlying causes, and optimizing perioperative care improves long-term outcomes.

Quick Takeaways

- High-risk medications—benzodiazepines, gabapentinoids, tricyclic antidepressants, and anticholinergics—should be minimized or carefully dosed.
- Non-pharmacologic strategies, reorientation, sleep optimization, early mobilization, and family involvement are essential for prevention.
- Delirium can be hyperactive (agitated) or hypoactive (lethargic), and hypoactive forms are more easily missed.
- Confusion Assessment Method (CAM) is a practical tool to help diagnose delirium.
- Once delirium occurs, treat underlying contributors—pain, infection, metabolic disturbances, constipation, urinary retention—while using antipsychotics only if needed.
- Delirium episodes can predict long-term cognitive decline, making prevention and early recognition clinically critical.

This episode explores delirium after surgery, highlighting high-risk medications, prevention strategies, clinical recognition—including both hyperactive and hypoactive forms—diagnosis, management, and the potential for long-term cognitive consequences.

Resources

Provider Resources:

- 5 Step Implementation Tool
- Multimodal Analgesia for Surgical Practice
- Guidelines on Limiting Opioid Use in the Perioperative Setting