



# Geriatric Fast Facts

## Topic: Psychotropics in Delirium

In some cases, **psychotropic medications** may be required to treat **the symptoms of delirium** (**not the delirium!**) They should be used **only** when the patient is experiencing significant distress or posing a risk to self or others. When symptom control is deemed necessary and environmental strategies are ineffective, a cautious trial of psychotropic medication is warranted.

Unfortunately, there is limited evidence published data to guide treatment. A review by the Cochrane Collaborative found only one high-quality randomized trial (1), and from this data it recommends that low-dose [haloperidol](#) (0.5 to 1.0 mg PO, IV or IM) be used to control agitation or psychotic symptoms. Haloperidol is associated with a low frequency of sedation and hypotension. The onset of action is 30 to 60 minutes after parenteral administration

Elderly patients with dementia are more likely to experience severe extra pyramidal side effects (EPS) with haloperidol. The newer **atypical antipsychotic agents**, [quetiapine](#), [risperidone](#), and [olanzapine](#) have fewer EPS, and in small studies appear to have similar efficacy to Haldol. However, concerns have been raised about a possible small increase in risk for cerebrovascular events and mortality when they are used in patients with dementia.

**Benzodiazepines** (eg, [lorazepam](#) 0.5 to 1.0 mg) have a quicker onset of action (5 minutes after parenteral administration), but often increase confusion and sedation. Benzodiazepines are the drugs of choice **only** in cases of sedative drug and alcohol withdrawal. However, in small doses they may be useful adjuncts to antipsychotic treatment.

(1) Jackson, KC, Lipman, AG. Drug therapy for delirium in terminally ill patients. In: The Cochrane Library, Issue 2, Chichester, UK: John Wiley & Sons, 2004