DELIRIUM, DEMENTIA AND DEPRESSION

(Important to remember that delirium, dementia, and depression can be co-occurring)
(Confounding factors such as age, sensory impairment, education, & cultural background should be considered when making assessment)

CLINICAL FEATURE	DELIRIUM	DEMENTIA	DEPRESSION
Definition	Characterized by acute & fluctuating onset of confusion, disturbances in attention, disorganized thinking &/or decline in level of consciousness.	Gradual & progressive decline in multiple areas of cognitive processing eventually leading to significant inability to maintain performance in ADLs & IADLs.	A cluster of depressive symptoms that are of such intensity they are out of the ordinary for that individual.
Onset	Sudden/rapid: hours to days; depends on cause; often worsens at twilight or in darkness.	Insidious/slow over months & years; often initially unrecognized; rapidity of progression depends on cause.	Can coincide with major life changes; often abrupt, but can be gradual.
Course	Typically reversible with determining cause & appropriate treatment; can fluctuate over 24 hour period & worsen at night. Can cause spiral of health deterioration; associated with acute physical illness.	Symptoms of cognitive decline gradual and progressive; may see more deficits with increased stress and/or change in environment. Vascular type dementias may show more fluctuation as opposed to Alzheimer's type steady slow progression.	(Typically) can be worse in the morning; situational fluctuations, but less so than with delirium. Targeted symptoms: depressed or irritable mood, anhedonia, low self-esteem, difficulty making decisions, hopeless/helpless, recurrent thoughts of death, change in appetite, sleep disturbance. Can resolve fairly quickly with treatment (or on its own if milder) or symptoms may continue for a longer course.
Progression	Typically abrupt, but can persist from weeks to months or longer if untreated.	Slow, irreversible. Dx. based on >6 months confusion.	Variable: can abruptly coincide with major life events, but can also be gradual
Duration	Hours to months, depending on cause, access to treatment & resolution of underlying precipitant.	Months to years; irreversible.	(At least six weeks); can be several months to years. For purposes of PASRR evaluation, if other indications indicate, do not wait six weeks.
Awareness: ability for external focus of environment	Reduced: in and out of consciousness, inattentive, easily distracted.	May be aware of memory loss, & try to conceal. With progression, awareness decreases.	Person may complain of memory loss, can be indication of depression.
Alertness	Fluctuates: in & out of consciousness; lethargic to hyper vigilant.	Alert but confused/ disoriented: consciousness not clouded until terminal.	May appear to have reduced consciousness if severely depressed. May appear lethargic, distractible, preoccupied.
Attention	Strikingly short, wandering attention span, easily distracted, hard time following directions.	Not uncommon to be reduced.	Can include Poor concentration, distractibility, and reduced attention due to apathy.
Orientation	Impaired; severity varies with severity of the delirium.	Generally normal in very early stages of illness. Gradual increase in Disorientation as illness progresses	May appear disoriented due to apathy; and may appear distractible, preoccupied.

Speech	May be slurred, language difficulties.	Normal speech in early stages, word finding difficulties and other language problems later such as aphasia, agnosia.	May be delayed, poverty of speech, flatness.
Memory	Recent and immediate impaired.	Impairment of memory gradually worsens. Typically effects recent memory first and then remote or long term memory later.	Selective or patchy impairment; islands of intact memory; evaluation often difficult due to low motivation.
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Thinking	Thought process can be either slowed or accelerated, but disorganized, distorted, fragmented.	Cognitive decline with problems in memory plus one or more of the following: (aphasia) (apraxia); lack of insight, inability to do calculations, impairment of abstract thinking, etc..	Can be Intact, but with themes of hopelessness, helplessness or self-deprecation. Can appear impaired due to lack of concentration or lack of interest.
Perception	Distorted: illusions, delusions and *visual* hallucinations; difficulty distinguishing between reality & misperceptions.	Misperceptions usually absent, until later in illness: Common delusions: theft & infidelity of spouse.	Occasional delusions with elders. Common themes: poverty, worthlessness, ill health.
Psychomotor Behavior	Markedly variable; hypokinetic; hyperkinetic; psychomotor agitation.	Initially normal; may have apraxia later in illness.	Variable; psychomotor retardation or agitation/ restlessness.
Sleep/Wake Cycle	May be disturbed, with cycle reversed; may evidence muscle-jerking during sleep.	May be disturbed, with an individual pattern occurring most nights; day-night reversal.	Disturbed; early morning awakening, difficulty falling or staying asleep. Can be hypersomnolent.
Behavioral Features	May have drastic mood swings; hyperarousel; risk of assaulting others; attempts to escape; exaggeration of personality type. "Quiet delirium": subdued, hypokinesis.	Affect can be superficial, blunted, inappropriate. Mood can become labile; attempts to conceal deficits in intellect; personality changes; can become increasingly agitated	Affect blunted or flat; dysphoric mood; can focus on exaggerated and detailed complaints; may express delusional negative themes.
Assessment	Inattentive, distracted from task; numerous errors. Get H&P: check for abnormal lab work – electrolytes, blood count, UA, etc. ADLs/ IADLs; ETOH or street drug use; misuse of prescribed medications; abnormal response to change in prescribed medications; in baseline cognitive function; pain scale.	Increased difficulties noted by family, frequent near-miss answers; struggles with test; great effort to find an appropriate reply; frequent requests for feedback on performance, attempts to change subject/ divert assessor's attention away from exam, confabulation of answers.	At times subject acknowledges depression, at times denies any difficulty; frequently answers "don't know;" little effort; frequently gives up; indifferent toward test, does not care or attempt to find answer.

References:

AGS Foundation for Health in Aging, (June, 2005). *Delirium (Sudden Confusion)* Available from Aging in the Know, 350 Fifth Ave., Ste 801, NY 10118, http://www.healthinaging.org/AGINGINTHEKNOW/chapters_ch_trial.asp?ch=57

Bronx VA GRECC Interdisciplinary Curriculum: Geriatrics, Palliative Care and Interprofessional Teamwork (nd). *Module 15: Depression, Delirium and Dementia.* www.mssm.edu/grecc/modules/Module15.pdf

Registered Nurses Association of Ontario (Nov., 2003) *Screening for Delirium, Dementia and Depression in Older Adults.* http://www.rnao.org/Storage/12/645_BPG_DDD.pdf

Colorado PASRR Operations (March, 2008) *Delirium, Dementia, Depression*