Gerencia de Atención Integrada Alcázar de San Juan

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ACUTE CONFUSIONAL STATE: CASE REPORT

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Background

- 78-year-old femail admitted to the hospital with a diagnosis of a hip fracture
- Past medical history: hypertension, type-2-diabetes, atrial fibrillation, Graves' disease, dyspepsia
- Domiciliary medication: omeprazole 20mg/24h, tiamazole 10mg/24h, apixaban 5mg/12h, metoprolol 15mg/12h, enalapril 20mg/24h, atorvastatin 40mg/24h, alprazolam 0,5mg/24h

Purpose

- To report a case report of acute confusional state (ACS)

Methods

- Medication reconciliation, Electronic medical records review, Patient Interview

Results

- It was carried out medication reconciliation checking patient adherence and discrepancies
- Alprazolam has no indication in this patient and it is a potentially inappropriate drugs in the elderly (PRISCUM 2010 criteria). The pharmacist recommended to taper it down slowly but it was abruptly stopped. The pharmacist also detected omeprazole duplicity. The patient required surgery, the pharmacist adviced to stop apixaban 36h before the procedure.
- On day 1, it was prescribed: tramadol 100mg/8h and ketorolac 30mg/8h and rescue pethidine 50mg/4h for hip pain and amitriptyline 25mg/24h for neuropathic pain. The pharmacist proposed ketorolac dose reduction (which was accepted), amitryptiline starting dose of 10mg at bedtime and an alternative opioids to pethidine (not recommended in elderly population) but it was not accepted by the physician. At night the patient suffered from fevers and chills. Temperature, 39°C, blood pressure 120/90mm Hg, and heart rate 110 beats/minute. Chest radiography revealed a community-acquired pneumonia and started levofloxacin 500mg/24h. On day 2, she developed severe agitation, fluctuating level of consciousness and visual hallucinations (the presence of a cat in her room).
- She was diagnosed of an ACS which prompted a prescription for haloperidol 5mg. The pharmacist suggested anticholinergic drugs discontinuation (amitriptyline and pethidine) and low dose benzodiazepine re-introduction and other non-pharmacological measures with a favourable evolution of the patient

Conclusions

- ACS is a clinic multifactorial syndrome. It could have been prevented avoiding factors known to cause or aggravate it, for instance, avoiding anticholinergic drugs prescriptions, withdrawal state (benzodiazepine), dehydration, inmobilization or sleep disturbances.
- Pharmacist contributed in the integral patient attention providing continuity in individualized pharmacotherapeutic care.
- Pharmacist interventions included correcting/clarifying orders, providing drug information, suggesting alternative therapies and dose adjustments, checking discrepancies and improvement SCA manifestations

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