The Missed Delirium in an Advanced Cancer Patient with Severe Pain Referred to Palliative Care Unit

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Objectives:

Pain and delirium are commonly reported in palliative care with advanced cancer. Delirium is a common neuropsychiatric condition characterized by acute changes in cognition and disturbance of consciousness (1). High expression of delirium symptoms can be misinterpreted as pain and lead to unnecessary medical interventions and delay in appropriate treatment (2,3). We present a case of missed delirium referred to palliative care unit for pain due to metastatic breast carcinoma.

Case report:

A 40 years old female patient was referred to palliative care unit with uncontrolled pain. She had breast cancer with multiple bone and brain metastasis. She was using transdermal fentanyl 50 mcg/hr, steroids and antiepileptics on admission to palliative care unit. Subcutaneous morphine was administered by her primary doctor for pain relief. She was agitated and unable to cooperate to define her pain. Haloperidol 20mg/day was started parenterally after the diagnosis of hyperactive delirium. She didn't need any rescue opiod analgesic during her stay at hospital and 4 days later, she was discharged with transdermal fentanyl 50 mcg/hr and haloperidol 3mg orally.

Conclusion:

A significant number of patients with missed delirium are referred to palliative care clinics for treatment of pain. Opioid escalation to address the patient's complaints may contribute to worsening of the symptoms of delirium. With correct diagnosis of delirium in these patients, opioid dose reduction, rotation and the use of anti-psychotics could be initiated earlier and the symptoms of delirium can be potentially reversed. We think that routine screening of cancer patients for delirium is necessary.

References:

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