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Delirium Management and Antipsychotic Use: Explanations and Perspectives

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Dear Editor,

We appreciate the valuable feedback and contributions provided by our colleague, Bağcaz, in the letter titled " Follow-Up of Delirium Patients: Antipsychotic Use Can Be Another Confounding Factor for Prognosis"(1) regarding our article, "Six-Month Follow-Up of Delirium Patients: Evaluation of Anxiety, Depression, Cognition, Functioning, and Mortality," (2) published in the Van Medical Journal. We are pleased that our study has contributed to the discourse on this critical issue and acknowledge the importance of considering antipsychotic use as a potential confounding factor in the prognosis of patients with delirium. The role of antipsychotics in the management of delirium continues to be a subject of debate. While pharmacological interventions are commonly used in clinical practice to manage hyperactive delirium, current guidelines emphasize prioritizing non-pharmacological approaches (3). As highlighted in the letter, inappropriate or prolonged use of antipsychotics can lead to additional complications, such as extrapyramidal symptoms, anticholinergic side effects, prolongation of the corrected QT interval (QTc), particularly in elderly patients. Indeed, prior studies and Food and Drug Administration (FDA) warnings have associated long-term antipsychotic use with an increased risk of mortality (4). We agree that the duration, type, and dosage of antipsychotic use could potentially influence delirium outcomes, including mortality rates. However, as stated in our study, our primary aim was to evaluate the overall psychological, cognitive, and functional outcomes of delirium patients over a six-month period, rather than focusing on specific pharmacological interventions (2). The multifactorial nature of delirium and its outcomes makes it challenging to isolate individual contributions, such as antipsychotic use, without a study specifically designed to address this particular variable. Future research with larger sample sizes and controlled methodologies is needed to further investigate the association between antipsychotic use and mortality in delirium patients. In response to the questions raised by Bağcaz (1) regarding our study, we would like to provide additional details concerning antipsychotic use in our study. All delirium patients included in our study were recommended to receive antipsyhotic use. Haloperidol was recommended for 96% of the patients (n = 48), and risperidone was recommended for 4% (n = 2). The mean haloperidol dose was 1.61 mg ± 0.76 mg, the mean risperidone dose was 0.5 mg ± 0.01 mg, and the mean duration of antipsychotic use was 8.42 days ± 3.64 days. When comparing these findings with current literature, we observe that antipsychotics are still frequently used in delirium management, despite recommendations supporting non-pharmacological interventions. A systematic literature review, encompassing 39 studies published between 2004 and 2023 from 13 countries, revealed that clinicians continue to utilize antipsychotics for delirium management (5). In this review, haloperidol, the most commonly used antipsychotic, was used at higher mean daily doses than recommended (2.75 mg, ±2.21 mg). Other commonly used antipsychotics were olanzapine (mean 11 mg, ±8.54 mg), quetiapine (mean 64.23 mg, ±43.20 mg) and risperidone (mean 0.97 mg, ±0.64 mg). The mean number of days treated with any antipsychotic ranged from 4 to 7 days (mean 3.6-16.8 days). The findings indicated that the dosage, frequency, and duration of antipsychotic use often deviated from evidence-

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based guideline recommendations. Clinicians continue to choose antipsychotics to manage delirium symptoms, particularly in situations with high workload pressures, in order to alleviate agitation and ensure the safety of patient and staff. The recommended approach is to use the lowest effective dose for the shortest possible duration (3). Although the duration we reported in our study slightly exceeds the recommended one-week period, it remains within a reasonable clinical range and antipsychotics were used at lower doses in our study compared to the review by Tomlinson et al. (5). As noted, the insufficient recognition of delirium remains a significant issue, and early diagnosis and intervention are crucial for improving patient outcomes. The emphasis on non-pharmacological interventions such as reorientation, early mobilization, sensory aids, and adequate hydration aligns with current best practices in delirium management and should be reinforced in clinical settings. We appreciate the author's thoughtful analysis and concur with the need for further research on the impact of antipsychotic use on delirium prognosis. Until more definitive findings emerge, clinicians should continue to approach antipsychotic prescriptions with caution, ensuring that their use is limited to situations where non-pharmacological strategies have proven insufficient, and that these medications are administered at the lowest effective dose for the shortest possible duration.

We once again thank the author for their valuable comments and hope that our study will encourage further research and discussion in this important field.

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