EMERGENCE DELIRIUM

By Jane Harvey
What is it??

- Emergence is the transition from anaesthesia to the full conscious state.
- Delirium is the group of difficult behaviours associated by fear & agitation & is exhibited during emergence.
- An altered state of neurological functioning.
- It can occur in all patient populations but is commonly seen in paediatrics, the elderly, the cognitive impaired or drug dependent.
Emergence delirium occurs in approx 5% of the general population but 12-30% of the paediatric population but can also occur in the elderly, drug dependant & patients with a psychiatric history.

Emergence delirium is a well researched but still poorly understood scenario which usually occur in the first 10 minutes after arrival in Recovery and may lat up to 15-20 minutes.
Causes:

- Withdrawal Psychosis - withdrawal from alcohol & illicit drugs
- Toxic Psychosis - exposure to toxins in the OR
- Circulatory & Respiratory Causes - Hypoxemia & Hypercarbia due to CNS Depression/airway Obstruction/perfusion deficits. Hypoxemia is the cause until all others eliminated
- Functional Psychosis - brief reaction of paranoia not caused by organic abnormalities
Most likely causes in Children:

- Rapid emergence without appropriate analgesia
- Young or advanced age
- Poor adaptability
- Nil previous surgery
- Increased blood loss intraoperatively
- Increased preoperative anxiety
- Specific types of surgeries- ENT, ophthalmological, breast or abdominal
Differential diagnosis:

- Pain
- Withdrawal
- Respiratory/circulatory causes
- Medications
- Altered thermoregulation
- Anxiety
- Bladder distention
- Metabolic/electrolyte disturbances
Those difficult behaviours:

- Excitement
- Disorientation/inability to be consoled
- Screaming/crying
- Kicking/thrashing/non purposeful movements
- Non responsive
- Holding themselves rigid
- Restlessness
- Removing/dislodging IV, drains, dressing etc
Emergence Delirium V Pain

- Difficult to assess based on traditional VAS, or paediatric “faces” systems in small children.
Wong Faces Pain Rating System

A little too simplistic for this situation.
FLACC Paediatric Pain scoring

Works well for children aged 2 months to 7 years. Used for children who cannot self report but are not cognitively impaired.
Treatment

- Rule Out Hypoxemia
- Treat any other causes
- Consider Sedation
- Maintain Patient Safety
Treatment:

- Begin with the basics- airway, breathing & circulation. Use adhesive pulse oximetre rather than a regular one – more likely to stay on when thrashing around in bed.

- Constant supervision, often more than one nurse required. Some gentle restraint may be required to prevent injury.

- Sit head of bed up, attempt to use Hudson Mask. Don’t use elastic strap, just hold the mask a few millimetres from the face.
More Treatment

- Reassure child, orientate to person, place or time.
- If parent present, support them, explain what’s going on
- Protect the IV site, it will be required for ongoing hydration
- Consider the use of opiates
- Feedback to anaesthetists- consider the use of Clonidine during anaesthesia, which has some mildly calming & sedative effects in the first 24hrs postop.
References:

- Burns S (2003) Delirium During Emergence from Anaesthesia: a case study Critical Care Nurse 23(1) 66-69
- Hudek K (2009) Emergence Delirium: A Nursing Perspective AORN Journal 89(3) 509-520