Hitna stanja kod demencije i psihičkih poremećaja u starijoj životnoj dobi

Dementia and Psychiatric Emergencies in the Elderly Population

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S obzirom na kontinuirano povećanje broja starijih osoba u ukupnoj populaciji u Hrvatskoj, za očekivati je da će se broj starijih osoba s akutnim psihičkim smetnjama koje zahtijevaju hitno zbrinjavanje sve više povećavati. Najčešći psihički poremećaji kod starijih osoba su: depresivni poremećaji, kognitivni poremećaji, demencija, poremećaji vezani uz uzimanje alkohola, poremećaji vezani uz druga zdravstvena stanja i lijekovima izazvani poremećaji. Gerijatrijski bolesnici bi u pravilu prvo trebali biti pregledani od strane stručnjaka somatske medicine (internista, neurologa, kirurga) prije nego što se upućuju u hitnu psihijatrijsku službu, kako bi se ustanovilo da su primarne smetnje iz psihijatrijske domene. Izražena depresija, suicidalnost, agitacija, sklonosti lutanju i ostalim rizičnim ponašanjima kod kuće, izražena anksioznost i smanjena sposobnost brige o sebi, glavni su razlozi hospitalizacije kod ovih bolesnika.

/ Related to the fact of the continuous increase in the number of elderly people in the total population of Croatia, it can be expected that the number of elderly people with acute psychiatric disorders that require emergency care will increase. The most common psychiatric disorders found in the elderly are depressive disorders, cognitive disorders, dementia, alcohol-related disorders, disorders related to other health conditions and drug-induced disorders. Geriatric patients should, generally speaking, first be reviewed by a psychosomatic medical specialist (internist, neurologist, surgeon) before they are sent to psychiatric emergency services in order to establish that the primary complaint is connected with the psychiatric domain. Pronounced depression, suicidality, agitation, wandering tendencies and other home-based risk behaviours, with anxiousness and reduced self-care ability, are the main reasons for hospitalization.

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UVOD I DEFINICIJE

S obzirom na kontinuirano povećanje broja starijih osoba u ukupnoj populaciji u Hrvatskoj, za očekivati je da će se broj starijih osoba s akutnim psihičkim smetnjama koje zahtijevaju hitno zbrinjavanje sve više povećavati (1). Najčešći psihički poremećaji kod starijih osoba su: depresivni poremećaji, kognitivni poremećaji, demencija, poremećaji vezani uz uzimanje alkohola, poremećaji vezani uz druga zdravstvena stanja i lijekovima izazvani poremećaji (2-4). Predisponirajući čimbenici rizika za obolijevanje od psihičkih poremećaja u starijoj dobi uključuju: visoki komorbiditet, smanjenje kognitivnih sposobnosti, smanjenje u socijalnim interakcijama, smanjenja autonomije, financijska opterećenja, gubitak članova obitelji i prijatelja, gubitak posla (umirovljenje) (5). Razlozi posjećivanja hitne psihijatrijske službe kod ove populacije bolesnika mogu biti: nagla pojava halucinacija, sumanutosti ili paranoje, inkoherentno i dezorganizirano mišljenje, suicidalne ideje ili namjere, gubitak motivacije, antisocijalno ponašanje. Demencija i problemi u ponašanju, poremećaji spavanja, psihoze, agitirana stanja, deliriji uzrokovani drugim zdravstvenim stanjem ili lijekovima su također česti uzrok traženja psihijatrijske pomoći (6,7).

Pamćenje je proces pohranjivanja i reproduciranja ili vraćanja naučenih i pohranjenih informacija u svjesno. Pamćenje se može podijeliti na kratkoročno i dugoročno.

Amnezija je djelomičan ili totalni gubitak sposobnosti prisjećanja informacija ili iskustava iz prošlosti uz inače održano intelektualno funkcioniranje. Amnezija se može podijeliti na anterogradnu (sposobnost usvajanja novih informacija) i retrogradnu (sposobnost prisjećanja već naučenih informacija) (8,9).

Paramnezije su lažna sjećanja uzrokovana smetnjama prisjećanja. Konfabulacije spadaju u paramnezije. To su netočna i pogrešna (izmišljena) sjećanja koja bolesnik iznosi u namjeri

INTRODUCTION AND DEFINITIONS

Related to the fact of the continuous increase in the number of elderly people in Croatia, it is expected that the number of elderly people with acute psychiatric disorders requiring urgent care will increase (1). The most common psychological disorder in the elderly are depressive disorders, cognitive disorders, dementia, alcohol-related disorders, disorders related to other health conditions and drug-induced psychiatric disorders (2-4). Predisposing risk factors for psychiatric disorders in the elderly include high comorbidity, decline in cognitive abilities, decline in social interactions, decreased autonomy, financial burdens, loss of family and friends and occupational loss (retirement) (5). Reasons for employing psychiatric emergency service in this patient population may be a sudden appearance of hallucinations, delusions or paranoia, incoherent and disorganized thinking, suicidal ideation or intentions, lack of motivation and antisocial behaviour. Dementia and behavioural problems, sleep disturbances, psychosis, agitated conditions, deliriums caused by other health conditions or medications are also a common cause of searching for psychiatric help (6,7).

Memory is the process of storing and reproducing and/or restoring the learned and stored information consciously. Memory can be split into short-term and long-term memory.

Amnesia is a partial or total loss of ability to recall information or experiences from the past with maintained intellectual functioning. Amnesia can be divided into anterograde (the ability to receive new information) and retrograde (the ability to recall the already learned information) (8,9).

Paramnesia is false memories caused by a disorder of memory. Confabulation is a part of paramnesia, which is incorrect and wrong (fantastical) memories that the patient uses in order to

da prikrije „rupe“ u sjećanju. Konfabulacije se mogu naći kod bolesnika s amnezijom, s oštećenjem frontalnog režnja mozga ili bolesnika s nekim od poremećaja ličnosti.

Delirij, amnestički poremećaj i demencija svrstavaju se u kognitivne poremećaje kojima su zajedničke karakteristike oštećenja u sjećanju, gubitak sposobnosti govora i pažnje. Svaki gubitak pamćenja sam po sebi nije demencija (10,11).

Amnestički poremećaj je karakteriziran gubitkom sjećanja koji uzrokuje značajni dizabilitet u funkcioniranju uz intaktne izvršne funkcije i senzorij. Lijekovi koji se najčešće povezuju s amnezijom su benzodiazepini kao i antikonvulzivi, metotreksat i otrovi (živa, olovo i otapala). Alkoholom uzrokovani perzistirajući amnestički poremećaj kod kroničnog konzumiranja alkohola uzrokovan je nedostatkom vitamina (tiamina), a naziva se Korsakovljev sindrom. Sljedeći uzrok privremenog gubitka pamćenja vezanog uz alkohol su takozvani „*blackouts*“ (zatamnjenja sjećanja) (3).

Demencija je karakterizirana teškim kognitivnim oštećenjima, ponajprije progresivnim gubitkom pamćenja i ostalih izvršnih sposobnosti kao što su apstraktno mišljenje, inteligencija, učenje, sposobnost govora, orijentacija, percepcija, koncentracija, pažnja, sposobnost uvida i socijalne vještine bez oštećenja svijesti (12,13).

KLINIČKA SLIKA

Bolesnici s demencijom rijetko se sami javljaju u hitnu psihijatrijsku službu. Uglavnom ih dovode članovi obitelji zbog poremećaja u njihovom ponašanju, kao što su lutanja, neprimjereno seksualno ili osobno ponašanje, potencijalno opasno ponašanje (ostavljanje upaljene pećnice) ili psihičkih poremećaja kao što su psihoza, depresija, paranoja, agitacija, promjene raspoloženja, smetnje spavanja i apetita (6). Obično se to događa u noćnim satima i u dane

conceal the “holes” in their memory. Confabulation can be found in patients with amnesia, with damage of the frontal lobe of the brain or in some patients with personality disorders.

Delirium, amnestic disorders and dementia are classified into cognitive disorders with common characteristics of impairment in memory, loss of speech skills and attention. Each loss of memory alone does not represent dementia (10,11).

Amnestic disorder is characterized by a loss of memory which causes significant function disability with the intact executive function and sensory. Drugs that are most commonly associated with amnesia are benzodiazepines as well as anticonvulsants, methotrexate and poisons (mercury, lead and solvents). Alcohol-induced persistent amnesic disorder with chronic alcoholism caused by a lack of vitamins (thiamine), is called Korsakoff syndrome. Causes of temporary memory loss that are also associated with alcohol are so-called “blackouts” (3).

Dementia is characterized by severe cognitive impairments, primarily by progressive loss of memory and other executive abilities such as abstract thinking, intelligence, learning, speech ability, orientation, perception, concentration, attention, insight and social skills with intact consciousness (12,13).

CLINICAL PRESENTATIONS

Patients with dementia rarely come to a psychiatric emergency service by themselves. They are most commonly taken there by their families because of behavioural disorders such as wandering, inappropriate sexual or personal behaviour, potentially dangerous behaviour (leaving the oven switched on) or psychiatric disorders such as psychosis, depression, paranoia, agitation, mood swings, disturbance of sleep and appetite (6). This usually happens at night and at weekends when the family

vikenda kada obitelj provodi najviše vremena s bolesnikom i ima uvid u njegovo ponašanje, a u domovima za starije u to vrijeme (tijekom noći i vikendima) bude smanjena služba te se oni teško mogu brinuti o takvim bolesnicima. Početak psihijatrijskih simptoma kod ovih bolesnika kao što su anksioznost, promjene raspoloženja, kognitivne smetnje i psihotični simptomi mogu se povezati s nekim rizičnim čimbenicima kao što su nedavni smrtni slučajevi, preseljenja, separacije, nedavne promjene u medikamentnoj terapiji, različite somatske bolesti, od uroinfekcija do za život opasnih bolesti (karcinoma). Rani bihevioralni simptomi demencije uključuju dezinhibirano ponašanje i apatiju, koji mogu progredirati do agitacije. Nemir i agresivno ponašanje mogu biti posljedica deluzija koje su kod ovih bolesnika prisutne u 30-50 % slučajeva. Najteži dio kliničke slike za obitelj i okolinu su progesivne promjene bolesnikove osobnosti: socijalno povlačenje, introverzija, hostilnost, paranoja i iritabilnost. Mnogi bolesnici imaju i halucinatorna doživljavanja (osobito vidna) i sumanutosti, što su najčešći razlozi dolaska u hitnu službu. Stariji bolesnici s depresijom mogu imati probleme s pamćenjem koji bi u kliničara mogli pobuditi sumnju na demenciju. Ovo stanje se naziva pseudodemencija ili depresijom uzrokovana kognitivna disfunkcija. Ovi bolesnici imaju intaktnu orijentaciju, pažnju i koncentraciju i fluktuirajuće smetnje pamćenja. Obitelj svjedoči naglom nastanku promjena, a bolesnik je svjestan problema s gubitkom pamćenja (uglavnom kratkotrajnog pamćenja) i zabrinut je zbog toga (14).

Stanja konfuzije i dezorijentacije su stanja kod kojih je oštećena orijentacija u vremenu, prostoru ili drugim osobama, a rijetko i prema samome sebi. Iako je konfuzija obilježje organskih poremećaja, može se vidjeti i u nekim psihijatrijskim poremećajima kao što su shizofrenija, delirij, demencija, amnestički poremećaj i drugi poremećaji. Jedan od najčešćih uzroka akutno-konfuznog stanja u hitnoj psihijatrijskoj am-

spends more time with the patient and has insight into his or her behaviour, and during such periods (at night and at the weekend) in nursing homes staff numbers are reduced, and they can hardly take care of such patients. The beginning of psychiatric symptoms in these patients such as anxiety, mood swings, cognitive impairment and psychotic symptoms can be associated with some risk factors such as recent deaths, relocation, separation, recent changes in medication therapy, various somatic diseases, urinary infection or even life-threatening diseases (cancer). Early behavioural symptoms of dementia include disinhibited behaviour and apathy, which can progress to agitation. Fear and aggressive behaviour can be the result of delusions that are present in these patients in 30-50% of cases. For the family and the patient's environment, the hardest part of the clinical picture are progressive changes of the patient's personality: social retreat, introversion, hostility, paranoia and irritability. Many patients also have hallucinatory perceptions (especially visual ones) and delusions, which are the most common causes of seeking the assistance of emergency services. Older patients with depression may have memory problems that could cause the clinician to suspect there is presence of dementia. This condition is called pseudodementia or depression caused by cognitive dysfunction. These patients have intact orientation, attention and concentration and fluctuating memory impairment. The family witnesses the sudden emergence of changes, and the patient is aware of memory loss problems (mostly short-term memory) and is concerned about it (14).

The states of confusion and disorientation are states with impairment in the orientation in time, space or regarding other persons, and rarely regarding themselves. Although confusion is a feature of organic disorders, it can be seen in some psychiatric disorders such as schizophrenia, delirium, dementia, amnesia and other disorders. One of the most common

bulanti je delirij. Delirij je akutni, reverzibilni psihoorganski sindrom karakteriziran smanjenom mogućnosti reagiranja na vanjske podražaje i poremećajem svijesti, poremećajem senzoričkih sposobnosti, poremećajem spavanja i psihomotoričke aktivnosti, dezorijentacijom i poremećajem pamćenja. Delirij obično nastaje u kratkom razdoblju i ograničenog je trajanja te ima nekakvu organsku podlogu. Prodromalni znakovi i simptomi koji mogu prethoditi stanju delirija mogu biti: anksioznost, nemir, pospanost ili insomnija i tranzitorna halucinatorna doživljavanja. Delirij se pojavljuje kod više od 15 % svih hospitaliziranih bolesnika u općoj bolnici s većim udjelom (20-30 %) kod starijih osoba, osobito onih s već postojećim kognitivnim oštećenjima. Bolesnici s demencijom su visoko predisponirani za razvoj delirija. Delirij je ozbiljno i za život opasno stanje na koje uvijek moramo sumnjati kad kod bolesnika uočimo fluktuirajuće promjene u orijentaciji i konfuziji (15). Mogu se pojaviti vizualne, olfaktorne ili taktilne halucinacije, kao i razne sumanutosti. Bolesnici mogu pokazivati promjene raspoloženja od apatije do bijesa i razdražljivosti, koje ponekad vode i u agresivno ponašanje. Skrbnici se često mogu žaliti na poremećen ciklus spavanja i budnosti s vidnim pogoršanjem simptoma u večernjim satima, što je poznato kao tzv. sindrom zalazećeg sunca (engl. *sundowning syndrome).* Kod opservacije ovakvih bolesnika treba imati na umu da se psihički status kod njih može mijenjati iz sata u sat, tako da i uredan i lucidan psihički status prigodom pregleda može biti u kontradikciji s izjavama članova obitelji ili bolničkog osoblja, a što nas dodatno upućuje na sumnju da se radi o deliriju.

causes of the acutely confused state in psychiatric emergency service is delirium. Delirium is an acute, reversible psycho-organic syndrome characterized by reduced response to external stimuli and consciousness disorders, sensory abnormalities, sleep disturbances and psychomotor activity, disorientation and memory disorders. Delirium usually occurs in a short period of time and is of limited duration and has some organic basis. Prodromal signs and symptoms that may precede the state of delirium may be: anxiety, restlessness, drowsiness or insomnia and transitory hallucinatory perception. Delirium occurs in more than 15% of all hospitalized patients in the general hospital with a higher proportion (20-30%) in elderly, especially those with already existing cognitive impairment. Dementia patients are highly predisposed to the development of delirium. Delirium is a serious life-threatening condition that we must always suspect when we notice fluctuating changes in orientation and confusion in patients (15). Visual, olfactory or tactile hallucinations, as well as various delusions may occur. Patients may show mood swings from apathy to anger and irritability, which sometimes lead to aggressive behaviour. Caregivers often complain about a disturbed cycle of sleep and wakefulness with a worsening of symptoms in the evening, known as the so-called sundowning syndrome. When observing such patients, one should have in mind that their psychological status may vary from hour to hour, so that a normal and lucid psychological status during the examination may be in contradiction with the statements of family members or hospital staff, which further leads to suspicions of delirium.

KLINIČKA PROCJENA

Diferencijalna dijagnostika mogla bi se pojednostavniti i na sljedeći način: ako simptomi i imaju fluktuirajući tijek, treba misliti na delirij; ako postoje psihotični simptomi sa zaravnje-

CLINICAL EVALUATION

Differential diagnosis could be simplified in the following way: if the symptoms have a fluctuating course, delirium should be taken into consideration, and if there are psychotic symptoms

nim efektom, tada treba misliti na psihotične poremećaje kao što je shizofrenija; ako postoji opći kognitivni deficit s amnezijom, treba misliti na demenciju; ako postoje simptomi promjene raspoloženja, treba misliti na afektivne poremećaje.

Svakako treba izbjegavati bilo kakve lijekove prije postavljanja definitivne dijagnoze i otkrivanja uzroka konfuznosti i dezorijentiranosti u podlozi.

Akutna agitacija i psihotična stanja povezana s demencijom su hitna stanja u psihijatriji zbog rizika od samoozljeđivanja ili ozljeđivanja drugih, zbog agresivnog ponašanja ili odbijanja uzimanja lijekova, odbijanja liječenja, zbog općeg zdravstvenog stanja, zapuštene higijene, dehidracije (neuzimanja hrane i tekućine). Kod više od 50 % bolesnika s demencijom prezentiraju se psihotični simptomi poput paranoidnih sumanutosti ili halucinacija te oko 90 % pokazuje agitaciju tijekom trajanja bolesti. Ova dva klastera simptoma kod ovih bolesnika obično se pojavljuju istovremeno, naročito kada se razvija paranoja i strah prema skrbnicima. U ranim i srednjim stadijima demencije postoji visoki udio depresije koja može biti povezana i s visokim rizikom od suicidalnosti. Odbijanje hrane, tekućine, lijekova te ostalih neophodnih pretraga zbog demencije može kod bolesnika dovesti do ozbiljnog gubitka tjelesne težine sve do kaheksije. Tri najčešća lijeka koji mogu pojačati apetit su mirtazapin, olanzapin i megestrol acetat. Kod dementnih bolesnika s depresijom odbijanje hrane i pića može predstavljati indirektno suicidalno ponašanje. Bolesnicima s delirijem, agitacijom i suicidalnošću potreban je intenzivan 24-satni nadzor i intenzivna psihijatrijska skrb. Moramo imati na umu da dementni i delirantni bolesnici u jedinici intenzivne skrbi s konstantnom sestrinskom njegom, mogu vrlo brzo iščupati intravenske infuzije, nazogastrične sonde, urinarne katetere i drugo. U ovakvim akutnim situacijama psihijatar bi trebao pokušati komunicirati s dementnim

with a flattened effect, then one should think of psychotic disorders such as schizophrenia. If there is a general cognitive deficit with amnesia, one should think of dementia. If there are moody symptoms, one should think of affective disorders.

Certainly, any medications should be avoided before establishing a definitive diagnosis and detecting the cause of confusion and disorientation in the background.

Acute agitation and psychotic states associated with dementia are urgent state in psychiatry because of the risk of self-injury or injury to others due to aggressive behaviour or refusal of medication, refusal of treatment due to the general health status, neglected hygiene, dehydration (food and fluid unavailability). In more than 50% of patients with dementia there are psychotic symptoms such as paranoid delirium or hallucinations, and about 90% show agitation during the course of the disease. These two clusters of symptoms in these patients usually occur at the same time, especially when paranoia and fear of caregivers are developed. In the early and middle stages of dementia there is a high proportion of depression that may be associated with a high risk of suicidality. Rejection of food, fluids, drugs, and other necessary medical exams because of dementia can lead to serious weight loss, even to cachexia. The three most common drugs that can stimulate the appetite are mirtazapine, olanzapine and megestrol acetate. Refusal of food and beverages in patients with dementia suffering from depression may represent indirectly suicidal behaviour. Patients with delirium, agitation and suicidal activity need intensive 24-hour supervision and intensive psychiatric care. We must bear in mind that dementia and delirium patients in the intensive care unit with constant nursing care can rapidly rip out the intravenous infusion, nasogastric probe, urinary catheter and the like. In such acute situations, a psychiatrist should try to communicate with

bolesnikom na njegovoj razini ohrabrivajući pacijenta i pokušati ga orijentirati u prostoru, vremenu i prema drugim osobama (16,17).

Kod razgovora s ovakvim bolesnicima ne bi trebalo inzistirati na prisjećanju nekih događaja i naglašavati njihov gubitak pamćenja, nego ih treba ohrabrivati i pružiti im potporu. Također, treba vidjeti je li nas bolesnici dobro čuju i vide, nose li naočale i radi li im slušni aparat. S njima treba razgovarati polagano, koristiti jednostavne rečenice, izbjegavati kompleksna pitanja. Može se dogoditi i da se više puta tijekom razgovora treba ponovno predstavljati. Od velikog bi značenja tijekom razgovora s bolesnikom bilo imati u ordinaciji i njihove članove obitelji ili skrbnike. Probleme s pamćenjem treba uvijek razmatrati ozbiljno, a ne ih minimalizirati ili opravdavati kao normalnom pojavom u starijoj životnoj dobi ili ih odmah proglasiti simptomom depresije. U zadnje vrijeme identificiran je i prijelazni stadij između kognitivnih promjena vezanih uz normalno starenje i Alzheimerove bolesti, nazvan blagi kognitivni poremećaj. Blagi kognitivni poremećaj može se vidjeti u bolesnika s gubitkom pamćenja koji je izražen u većoj mjeri nego što bi bilo očekivano s obzirom na godine, a još ne zadovoljava kriterije za Alzheimerovu demenciju. Probir i longitudinalno praćenje kod ovih bolesnika su vrlo važni, jer se iz ove subpopulacije bolesnika regrutiraju oni s mogućom Alzheimerovom demencijom. Blagi kognitivni poremećaj smatra se visokim rizikom za razvoj Alzheimerove demencije.

Uzimanje podataka (heteroanamneze) od obitelji, prijatelja, zdravstvenog osoblja iz domova za starije i udomiteljskih obitelji je od velike važnosti kako bismo imali uvid u osnovno funkcioniranje i ponašanje bolesnika i usporedili ga sa sadašnjim (aktualnim) ponašanjem. Važne su nam detaljne informacije o prijašnjim psihijatrijskim liječenjima, somatskim, kirurškim i drugim liječenjima, naročito ozljedama. Također treba obratiti pozornost na eventualno

a demented patient at his level by encouraging the patient and trying to orient him in space, time and in relation with other people (16,17).

When talking to such patients, one should not insist on recalling some events and emphasizing their memory loss but should instead be encouraging and supportive. Also, we need to check if the patients hear and see us properly, whether they are wearing glasses and hearing aids. Talk to them slowly, use simple sentences, and avoid complex issues. You may also have to introduce yourself several times during the conversation. It would be of great significance to have their family members or caregivers in the clinic during the conversation with the patient. Memory problems should always be considered seriously, not minimized or justified as a normal occurrence in the elderly or immediately declare them the symptom of depression. Recently, a transitional stage has been identified between cognitive changes associated with normal aging and Alzheimer's disease, termed as mild cognitive disorder. Mild cognitive disorder can be observed in patients with memory loss which is expressed to a greater extent than is anticipated with respect to the patient age, and does not yet meet the criteria for Alzheimer's dementia. Probes and longitudinal monitoring in these patients are very important because patients in this subpopulation are recruited with those with possible Alzheimer's dementia. Mild cognitive disorder is considered a high risk for developing of Alzheimer's dementia.

Taking information from family, friends, health care staff from nursing homes and foster families is of great importance in order to have an insight into the basic functioning and behaviour of patients and to compare them with the current (actual) presentation. Important information on previous psychiatric treatments, somatic, surgical and other treatments, especially injuries, is important. Attention should also be paid to the neglect or abuse of the elderly. It is very important to exclude other causes and risk factors of

zanemarivanje ili zlostavljanje osoba starije životne dobi. Vrlo je važno isključiti druge uzroke i rizične faktore amnezije kao što su: anamneza traume glave, epileptički napadi, infekcije, tumori i slično. Važno je isključiti delirij i depresivni poremećaj i druge reverzibilne uzroke dementnih stanja prije nego što se zaključi da bolesnik ima demenciju. Kod bolesnika treba napraviti kompletan psihički status i MMSE (*Mini-Mental State Examination*). Uz standardne laboratorijske pretrage trebalo bi odrediti saturaciju kisika, vitamin B_{12}, folate, hormone štitnjače i VDRL (10,18,19). U daljnjoj obradi, koja nije u sferi hitne psihijatrijske ambulante, bilo bi preporučljivo učiniti rendgen toraksa, EEG, apolipoprotein E (Apo E), genotipizaciju, CT, PET-CT (10,20,21). Heteroanamnestički podatci su od velike važnosti kao i uvid u propisanu farmakološku terapiju koju bolesnik uzima i podatci o samoj adherenciji za navedenu terapiju. Moguće nuspojave vezane uz međusobne interakcije lijekova kod ovih bolesnika su vrlo česte. Kod ovih bolesnika se u pravilu često susreće i polifarmacija. Neke skupine lijekova također mogu izazvati promjene psihičkog statusa kod ovih bolesnika kao što su opijatski analgetici, kortikosteroidi, psihostimulansi, antihistaminici i antikolinergici. Stariji bolesnici s delirijem i depresijom mogu izgledati dementno i kada to nisu. Treba paziti kada se ova dva stanja pojave istovremeno - najvažnija klinička značajka je klinički tijek. Delirij nastaje naglo i ima fluktuirajući tijek simptoma, dok demencija ima postupni početak i statični ili progresivni tijek. Najčešće susrećemo delirij koji je superponiran na demenciju. Bez obzira na dob bolesnika, uvijek treba misliti na uzimanje alkohola i drugih sredstava ovisnosti (10,22).

POSTUPCI I INTERVENCIJE

Gerijatrijski bolesnici bi u pravilu prvo trebali biti pregledani od stručnjaka somatske medicine (internista, neurologa, kirurga) prije nego

amnesia, such as: history of head trauma, epileptic attacks, infections, tumours and the like. It is important to exclude delirium and depressive disorder and other reversible causes of dementia before it is concluded that the patient has dementia. Patients should make a complete mental status examination and MMSE (mini-mental status exam). Along with standard laboratory tests, oxygen saturation, vitamin B12, folate, thyroid hormones and VDRL should be determined (10,18,19). In further treatment, which is not in the sphere of psychiatric emergency services, it would be advisable to do X-rays, EEG, apolipoprotein E (Apo E), Genotyping, CT, PET-CT (10,20,21). Data from heteroanamnesis are of great importance, as well as insight into the prescribed pharmacological therapy that the patient is taking and the adherence to the therapy. Possible side effects of drug interaction in these patients are very common. Polypharmacy usually occurs in these patients as a rule. Some drug groups may also cause changes in the mental status in these patients such as opiate analgesics, corticosteroids, psychostimulants, antihistamines and anticholinergics. Older patients with delirium and depression may look demented even when they are not. Care should be taken when these two conditions appear simultaneously; the most important clinical feature is the clinical course. Delirium develops rapidly and has a fluctuating course of symptoms, while dementia has a gradual start and a static or progressive course. The most commonly encountered delirium is the one superimposed on dementia. Regardless of the age of the patient, one should always exercise caution regarding taking alcohol and other addictive drugs (10,22).

PROCEDURES AND INTERVENTIONS

Geriatric patients should first be screened by psychosomatic medicine specialists (internists, neurologists, surgeons) before referring to psy-

što se upućuju u hitnu psihijatrijsku službu, kako bi se ustanovilo da su primarne smetnje iz psihijatrijske domene. Ako je bolesnik somatski nestabilan, trebao bi biti zadržan u jedinici somatske medicine, a psihijatra bi trebalo uključiti konzultativno. Kada bolesnik jednom postane somatski stabilan, može se premjestiti na psihijatrijski odjel, ako je to klinički indicirano (6,23).

U planu postupanja glavna je dilema treba li ove bolesnike zaprimiti na psihijatrijski ili somatski odjel. Kod bolesnika s izraženom depresijom, suicidalnošću, agitacijom, sklonostima lutanju i ostalom rizičnom ponašanju kod kuće, izraženom anksioznošću i smanjenom sposobnošću brige o sebi, to su glavni razlozi hospitalizacije. Starije osobe imaju osobit rizik od suicida, pogotovo muške osobe koje su razvedene ili udovci (24,25). Starije osobe imaju veću prevalenciju depresije, imaju više somatskih bolesti, više su socijalno izolirani, imaju više kognitivnih smetnji i problema sa spavanjem. Kod starijih osoba zabilježen je manji broj pokušaja suicida, ali veći broj izvršenih suicida jer biraju smrtonosnije metode (26,27).

Kod bolesnika sa smetnjom pamćenja općenito ključno je otkriti uzrok takvog stanja i onda tretirati to stanje u pozadini. Ako je oštećenje pamćenja jako izraženo, a bolesnik nema obiteljsku i socijalnu potporu, indicirano je hospitalno psihijatrijsko liječenje (po mogućnosti na psihogerijatrijskom odjelu) do stabilizacije psihičkog stanja i mogućnosti adekvatnog vanbolničkog zbrinjavanja. Bolesnici s izraženom jakom anksioznošću, suicidalnošću, depresijom, deluzijama i halucinacijama, mogućim samoozljeđivajućim ponašanjem (lutanje) moraju se odmah hospitalizirati (1,28).

Kod prijama ovih bolesnika u psihijatrijsku bolnicu, svakako bi ih trebalo smjestiti na psihogerijatrijski odjel. Ne bi bilo zgodno osamdeset petogodišnjeg, starijeg, agitiranog i dementnog bolesnika staviti na odjel i u sobu s devetnaestogodišnjim maničnim bolesnikom. Boravak u

chiatric emergency services to find out whether the primary complaint is psychiatric. If the patient is somatically unstable, he should remain in the somatic medicine unit, and a psychiatrist should be consulted. Once the patient becomes somatically stable, he can be referred to a psychiatric unit if clinically indicated (6,23).

In the treatment plan, the main dilemma is whether these patients should be admitted to a psychiatric or somatic department. In patients with pronounced depression, suicidality, agitation, wandering tendencies and other home-based risk behaviour, along with anxiousness and reduced self-care ability, these are the main reasons for hospitalization. Elderly persons have a particular risk of suicide, especially men who are divorced or widowed (24,25). Elderly people have a greater prevalence of depression, have more somatic illnesses, are more socially isolated, have more cognitive impairment and sleep problems. Smaller number of suicide attempts have been reported in elderly people, but a greater number of suicides have been committed because they chose more lethal methods (26,27).

In patients with memory impairment, it is crucial to find out the cause of such a condition and then treat that condition in the background. If the impairment of memory is very pronounced, and in the case of a lack of family and social support, hospital psychiatric treatment (preferably in the psycho-geriatric department) is indicated to stabilize the mental state and the possibility of adequate outpatient care. Patients with severe anxiety, suicidal ideation, depression, delusions and hallucinations, possible self-neglecting behaviour (wandering) must be hospitalized immediately (1,28).

When these patients are admitted to a psychiatric hospital, they should be placed in a psycho-geriatric department, and it would not be convenient for an eighty-five-year-old, agitated and demented patient to be placed in the same department and room with a nineteen-year-old

bolnici (trajanje hospitalizacije) je obično duže kod ovih bolesnika u usporedbi s mlađim bolesnicima. Nažalost, iako neke ustanove imaju specifične programe za dementne bolesnike, ova subpopulacija bolesnika često nije sposobna sudjelovati u takvim programima. Očekivani ciljevi hospitalnog psihijatrijskog liječenja su uvođenje ili korekcija terapije, stabilizacija ponašanja, psihoedukacija obitelji i smještaj bolesnika u primjerenije ustanove, ako je to potrebno (29,30).

Hospitalizacija bolesnika s demencijom je potencijalno stresno iskustvo za pacijenta i obitelj. Rizik od komplikacija tijekom boravka u bolnici je prilično visok, i preporuka je izbjeći nepotrebne hospitalizacije za osobe s demencijom. Komplikacije tijekom bolničkog liječenja osoba s demencijom su učestale, a najčešće se pojavljuju upala pluća, otežano gutanje, uroinfekcije, padovi (npr. prijelomi kuka), sepse, slabija pokretljivost (funkcionalnost). Posebno su važni suradnja između stručnog osoblja i njegovatelja, kao i planiranje zbrinjavanja osoba s demencijom nakon bolničkog liječenja (1,31,32).

Kod agitiranih stanja kod ovih bolesnika primjenjuju se niske doze visokopotentnih tipičnih ili atipičnih antipsihotika. U pravilu bi trebalo izbjegavati niskopotentne antipsihotike kao što su promazin, klorpromazin, levomepromazin i kombinacije lijekova općenito koliko je god to moguće (33-35). Glavno pravilo kod primjene ovih lijekova u bolesnika s demencijom je općenito *„start low and go slow"*, dakle započeti s malom dozom i postupno povisivati dozu. Kod akutno psihotičnih i agitiranih bolesnika najčešće se primjenjuju sljedeći antipsihotici: haloperidol 0,25-2 mg, risperidon 0,5-2 mg, olanzapin 2,5-5 mg, flufenazin 0,5-5 mg, kvetiapin 25 mg. Najčešće se primjenjuje haloperidol, jer ima manje antikolinergičko djelovanje, manje aktivnih metabolita i smanjenju mogućnost izazivanja hipotenzije. Nadalje, njegove su prednosti što se može primanic patient. The length of stay in hospital (length of hospitalization) is usually longer with these patients in comparison to younger patients. Unfortunately, although some institutions have specific programs for dementia patients, this subpopulation of patients are often unable to participate in such programs. The expected goals of hospital psychiatric treatment include the introduction or correction of therapy, behavioural stabilization, family psychoeducation and patient accommodation in a more appropriate institution if necessary (29,30).

The hospitalization of patients with dementia is a potentially stressful experience for the patient and family. The risk of complications during hospital stay is quite high, and the recommendation is to avoid unnecessary hospitalization for people with dementia. Complications during hospitalization in people with dementia are frequent, and most commonly take the form of pneumonia, difficulty in swallowing, urinary-infection, falls (for example hip fractures), sepsis, poor mobility (functionalities). Of particular importance is the cooperation between professional staff and caregivers, as well as planning for the treatment of people with dementia after hospitalization (1,31,32).

In case of agitated conditions in these patients, low doses of high-potent, typical or atypical antipsychotics are used. As a rule, low-potency antipsychotics such as promazine, chlorpromazine, levomepromazine and combinations of drugs should be avoided as much as possible (33-35). The main rule in the use of these drugs in patients with dementia is generally "start low and go slow", therefore start with a low dose and gradually increase the dose. In the case of acute psychotic and agitated patients, the following antipsychotics are most commonly used: haloperidol 0.25-2 mg, risperidone 0.5-2 mg, olanzapine 2.5-5 mg, fluphenazine 0.5-5 mg, quetiapine 25 mg. Haloperidol is most commonly used because it has less anticholinergic

mijeniti peroralno u obliku tableta ili tekućine (kapi) te parenteralno, intramuskularno ili čak intravenski. Iako antipsihotici nove generacije imaju prednosti u pogledu nuspojava pred antipsihoticima prve generacije, potreban je oprez kod primjene novih atipičnih antipsihotika zbog povećanog rizika od cerebrovaskularnih nuspojava. Ako su antipsihotici u nekoliko doza neučinkoviti ili su kontraindicirani, ili je stanje uzrokovano sustezanjem od alkohola ili lijekova, preporuča se terapija diazepamom 5-10 mg ili lorazepamom 0,5-2,5 mg (36,37). Ako je bolesnik i dalje izrazito psihomotorno agitiran te može postati opasan za sebe i okolinu, treba razmotriti primjenu fizičkog sputavanja. Treba biti posebno oprezan s primjenom benzodiazepina, naročito dugodjelujućih kao što je diazepam, jer može izazvati akumulaciju i uzrokovati ozbiljne nuspojave kao što su: poremećaj koordinacije, konfuzija, prejaka sedacija, padovi ili čak dezinhibicija. Uvijek kada imamo neobjašnjivo stanje sedacije, smetnje hodanja, padove ili kognitivne smetnje, treba isključiti uzimanje benzodiazepina. Isto tako, nagli prekid uzimanja benzodiazepina kod ovih bolesnika može izazvati simptome sustezanja, uključujući delirantna i psihotična stanja te epileptičke napade (38-42).

Psihoedukacija članova obitelji je vrlo važna te ju treba započeti već u prijamnoj ambulanti. Briga za dementnog bolesnika može postati teret za svakoga, posebno za starijeg supružnika koji i sam ima tjelesnih i kognitivnih smetnji. Ako to kliničar uoči, potrebno je razmotriti uključivanje takvog bolesnika u drugu zdravstvenu ili socijalnu ustanovu s intenzivnijim nadzorom i skrbi o bolesnicima (43-46). Indikacija za hospitalizaciju ponekad je i iscrpljenost osoba koje o bolesniku skrbe odnosno neformalnih njegovatelja koje su također nerijetko starije životne dobi (supružnici) ili su zaposlene (djeca). Ponekad se u bolnicu zaprimaju osobe s demencijom koje žive same, a više ne mogu samostalno funkcionirati, te im

activity, less active metabolites and reduced hypotension. Furthermore, its advantage is that it can be administered orally in the form of tablets or liquids and parenterally, intramuscularly or even intravenously. Although the new generation of antipsychotics has less side effects in comparison with the first generation of antipsychotics, caution is required when using new atypical antipsychotics due to increased risk of cerebrovascular side effects. If antipsychotics in several doses are ineffective or are contraindicated, or if the condition is caused by alcohol or drug withdrawal, diazepam 5-10 mg or lorazepam 0.5-2.5 mg (36,37) is recommended. If the patient is still psychologically disturbed and can become dangerous to themselves and the environment, the use of physical restraint should be considered. Special care should be taken with the use of benzodiazepines, particularly long-acting like diazepam, as it may cause accumulation and cause serious side effects such as: coordination disorder, confusion, excessive sedation or even disinhibition. Whenever there is an unexplainable sedation condition, walking disturbances, falls or cognitive impairment, the use of benzodiazepines should be excluded. Likewise, an abrupt withdrawal of benzodiazepines in these patients may cause the symptoms of diarrhoea, including delirium and psychotic states and epileptic attacks (38-42).

Psycho-education of family members is very important and should start in the emergency department. Care for a demented patient can become a burden to everyone, especially for an older spouse who has self-cognitive and cognitive disabilities. If the clinician is aware of this, it is necessary to consider including such a patient in another health or social institution with more intensive supervision and patient care (43-46). The indication of hospitalization is sometimes the exhaustion of persons who are taking care of the patient and/or informal care givers who are also often older (spouses) or are employed (children). Sometimes peo-

se uz pomoć Centra za socijalnu skrb započinje organizirati smještaj u odgovarajuću ustanovu ili udomiteljsku obitelj (1,47-51).

ZAKLJUČAK

Svakom pacijentu s akutnim psihičkim smetnjama, bez obzira na dob, treba pristupiti temeljito i razborito kako bi se mogle donijeti ispravne odluke o daljnjim medicinskim postupcima, postavljanju dijagnoze i liječenju. S obzirom na već opisani široki spektar psihijatrijskih poremećaja koji se mogu pojaviti kod osoba starije životne dobi, osim samog pregleda pacijenta i anamnestičkih podataka, od velike važnosti su i heteroanamnestički podatci (podatci članova obitelji, osoba koje žive s pacijentom u istom kućanstvu, osoba koje su na razne druge načine uključene u pacijentov svakodnevni život). Jako bitno je isključiti postojanje somatskih poremećaja koji bi mogli biti uzrokom psihičkih simptoma kod takvih osoba, pa se naglasak stavlja na timski rad psihijatara i drugih specijalista (internista, neurologa, liječnika obiteljske medicine...), kako bi se što brže i bezbolnije, a sve na dobrobit pacijenta, došlo do postavljanja ispravne dijagnoze, i samim time započelo što ranije liječenjem. Izražena depresija, suicidalnost, agitacija, sklonosti lutanju i ostalim rizičnim ponašanjima kod kuće, izražena anksioznost i smanjena sposobnost brige o sebi, glavni su razlozi hospitalizacije ovih bolesnika.

ple with dementia who live alone and can no longer function independently are accepted to the hospital, and with the help of the Centres for Social Welfare they begin to arrange accommodation in the appropriate institution or foster family (1,47-51).

CONCLUSION

Any patient with acute mental disorder, regardless the age of the patient, should be approached thoroughly and reasonably so that the correct decisions on further medical procedures, diagnosis and treatment could be made. Given the broad spectrum of psychiatric disorders that may occur in elderly persons, apart from the examination and the medical history of the patient, heteroanamnestic data (data from family members, persons living with the patient in the same household, persons that are in many different ways involved in the patient's daily life) is also of great importance. It is very important to exclude the existence of somatic disorders that may be the cause of psychological symptoms in such persons, so emphasis is placed on the teamwork of psychiatrists and other colleagues (internists, neurologists, family medicine physicians, etc.), so that an accurate diagnosis and treatment is made as fast and as painlessly as possible for the benefit of the patient's wellbeing. Pronounced depression, suicidal ideation, agitation, a tendency to wander and other high-risk behaviours at home, anxiousness and reduced ability to care for oneself are the main reasons for hospitalization in these patients.

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