3-841 Questioning Charles Bonnet syndrome

TIPS Question:

A 95-year old resident becomes delirious easily. She is on Duragesic 50 mcg for pain, Indocide for gout, Ativan for chronic anxiety. She also has macular degeneration. She is having hallucinations – seeing & hearing a preacher telling everyone about an abortion she had when she was young. We have stopped each medication for one week without any change. Wondering if she has genon baray syndrome? Any ideas to help case.

Response:

Such a complex clinical scenario makes care planning a challenge. Using the 6-Question template is a good starting point.

The first task is to clearly identify the problem/issues. The resident was taking analgesia, but it is not clear as to the physical problem for which this is treatment. Is this problem now resolved? The medication for gout is discontinued so we assume the physical problem has resolved. You mention as well a chronic anxiety. Is the anxiety related to a long-standing mental health problem or is the resident cognitively impaired and anxious, as she is unable to understand her environment? The resident's family/friends, as your Partners in Care, may help you understand the resident's anxiety more clearly. Medication can, indeed, precipitate delirium. Depending on how long a resident is on medication it is always advisable to withdraw medication slowly. Too rapid a discontinuation of some medications can, in fact, cause delirium. Also, some medications have a longer half-life and stay active a long time. If involved in a delirium, this can take weeks to resolve. Of course pain can, in itself, cause delirium so the monitoring of verbal and non-verbal responses is crucial to ensure the resident is not responding to her pain. Your manual provides examples of pain assessment tools.

As part of your assessment, you need an indication of the resident's cognitive status. Cognitive impairment would see the resident more vulnerable to delirium from any root cause.

The observation that the resident's hallucinations may be related to her macular degeneration is a good one. You have identified the syndrome known as Charles Bonnet Syndrome. Charles Bonnet Syndrome is characterized by visual hallucinations in patients with decreased vision. Although varied in location, neurologic lesions are frequently present. The management of this syndrome can be controversial because of the erratic response that has been seen in several therapeutic approaches. Even identical neuroleptics can produce a decrease in the occurrence of hallucinations in some individuals with the syndrome, but no change in others. This could be because of the differences in the structural neurological lesions from one person to another.

The resident is in significant distress. Through your P.I.E.C.E.S. assessment, particularly factors around her physical status and environment, may provide strategies for care. Hallucinations, especially those with negative content, such as experienced by this resident can be very disturbing. A review of how to assess and monitor the "D's" caused by delusions or other thought disorders as well as the Do's and Don'ts of interacting with the person may assist you in supporting this resident while the cause of her distress and the most appropriate interventions are being explored.

Please note: *TIPS information should be used similar to the way you would use information from a text book! TIPS is not intended to serve as an individual consultation service! P.I.E.C.E.S. participants should use this information in context and always work closely with the family physician involved in the care of the resident or client and with other Partners In Care to find solutions to individual resident/client issues.*