Received: 23 April 2020 | Accepted: 25 April 2020
DOI: 10.1002/gps.5318

LETTER TO THE EDITOR

International Journal of Geriatric Psychiatry WILEY

Management of older people during the COVID-19 outbreak: Recommendations from an Italian experience

Dear Editor,
The current COVID-19 outbreak in Italy has predominantly affected older people, particularly those over 75 years. Older people are unquestionably a frail segment of the population because of several comorbidities, they take more medications than younger people and are more frequently disabled. The Italian Government recommended a strict lockdown to protect them and guaranteed additional social services, like free home delivery of medications and grocery shopping for people over 65 years. Despite such measures, death rates among older people are dramatic. As of 22 April 2020, official data by the Italian Ministry of Health[1] show that 173 730 were COVID-19$^+$ according to laboratory tests; the highest number of deaths and the highest case fatality rate (CFR) were found among those older than 60 years (95%, CFR 89.5%).

Some preliminary data from the Italian National Institute of Health[1] suggest that in nursing homes there have been particularly high rates of deaths among residents. In most of these facilities, external visits were forbidden aiming at reducing the probability of infection, but the effect of this measure is uncertain, while it is certain that the sudden block to any contacts with relatives created a comprehensible anguish among many older people, particularly among those cognitively healthy.

The management of older COVID-19$^+$ patients frequently includes delirium which is particularly challenging. The DSM-5[2] defines delirium a neuropsychiatric syndrome with impairment of many cognitive functions that develops as the result of one or more acute clinical problem or because of drugs or due to mixed etiology. It might represent the phenomenological manifestation of worsening clinical conditions and it may represent the pivotal sign of imminent death.

1 | SOME TREATMENT RECOMMENDATIONS: THE PSYCHOVID DECALOGUE

Based on the experience gained in the management of many older inpatients with COVID-19, and in accordance with some of the main guidelines available in this area, we wish to suggest some essential tips for clinicians managing older patients showing signs of delirium.[3-9]

In general, it is recommended that each patient should receive assistance aimed at preventing delirium. Patient mobilization in a chair should be encouraged. In emergency, that is, when the patient is bedridden, agitated and could harm himself or others—pharmacological treatment should be considered.

TABLE 1 All the above-mentioned drugs are off-label in the treatment of delirium

Suggested treatments for non-terminal patients with delirium (modified from SIGN[2] and NICE delirium guidelines[6])			
Drug	**Single starting dose**	**Maximum dose in 24 hours**	**Cautions**
Haloperidol	0.5 mg im, 0.5 mg oral	2 mg im, 2 mg oral	It can prolong QTc. It can cause extrapyramidal signs
Risperidone	0.25 mg oral	1 mg in several doses	It can cause extrapyramidal signs
Promazine	50 mg im	300 mg im	It may lead to excess of sedation. Not indicated if coagulation problems. It can prolong QTc
Quetiapine	25 mg oral	200 mg oral	It can prolong QTc
Lorazepam	0.5 mg oral, 0.5 mg-1 mg im	2 mg oral, 2 mg im	Caution in acute renal failure

Suggested treatment in terminal patients with delirium as recommended by the Italian Society of Palliative Care		
Drug	**Dose**	**Maintenance**
Midazolam	2.5-5 mg iv	10-120 mg/daily, 1200 mg iv
Morphine	5-20 mg with midazolam	0.01-0.02 mg/kg/h
Haloperidol	With midazolam and morphine	5-100 mg/daily

Note: Palliative sedation is a procedure aimed at controlling unbearable sufferance due to untreatable symptoms and its goal is not death[14]; therefore, palliative sedation is empirically and ethically different from euthanasia or medical-assisted suicide and it cannot be used as alternative to euthanasia and medical-assisted suicide (Position statement on Euthanasia and Medical Assisted Suicide, Italian Society of Palliative Care, 2017).

 © 2020 John Wiley & Sons Ltd

1. Each patient at risk of delirium should be evaluated with a screening tool (eg, the 4AT).[10,11]
2. Prevention of delirium is appropriate acting on precipitating factors. These interventions should include: prevention of constipation, prevention of possible sources of pain (eg, use of specific cushions to avoid bedsores in patients with non-invasive ventilation), maintenance of adequate levels of oxygenation, prevention of urinary retention and de-escalation or discontinuation of medications with marked anticholinergic activity.[12]
3. If the clinician observes a substantial and quick behavioral change, it is mandatory to identify and treat triggering causes: pain, urinary retention and constipation are among the most common.
4. It is not appropriate to prescribe medications as needed. The identification of the target symptom of intervention (eg, agitation) is crucial.
5. It should be emphasized (Table 1) that the use of benzodiazepines is dangerous (unless COVID infection is comorbid with suspected delirium tremens) as they promote respiratory depression, they can worsen cognitive impairments and can increase the risk of falls and hip fractures.
6. Antipsychotic drugs should be used with extreme caution in older people, especially in patients affected by Parkinson disease, Parkinsonism or Lewy body disease. Among second-generation antipsychotics, quetiapine can represent an option (it has no extrapyramidal effects and a wide therapeutic range).
7. The most used antibiotics have no significant interactions due to a prevalent renal metabolism (eg, tazobactam, piperacilline and doxicilline [the latter has a 50% liver metabolism]). Metronidazole, as well as cloroquina, hydroxycloroquina and lopinavir have many interactions with antipsychotics, resulting in prolonged QTc, while ritonavir may affect the plasmatic concentrations of most antipsychotics.[13]
8. A complex management issue has to do with the adaptation and the tolerance of older COVID-19 patients to several examinations and treatments they are receiving, to the use of tools to support respiratory functions (masks, NVI, etc.) and instruments for individual protection (masks).
9. The use of restraint devices (eg, safety bed rails, clamps, etc.) should be discouraged in all patients with hyperactive delirium, but sometimes it might be required to ensure the best assistance.

   Delirium can evoke considerable stress for staff as well as for the patient. If possible, recommendations (available at https://www.sign.ac.uk/pat157-delirium) should be provided to staff.[5]

CONFLICT OF INTEREST

None declared.

Ester di Giacomo[1,2]
Giuseppe Bellelli[3]
Gianluca Peschi[4]
Stefano Scarpetta[5]
Fabrizia Colmegna[1]
Giovanni de Girolamo[6]
Massimo Clerici[1,2]

[1]*Department of Mental Health and Addiction, Health Care Trust, ASST Monza, Monza, Italy*
[2]*School of Medicine and Surgery, University of Milano-Bicocca, Milan, Italy*
[3]*Department of Geriatric and Internal Medicine, University of Milano-Bicocca, Milan, Italy*
[4]*Department of Social and Health Care, Health Care Trust, ASST Monza, Monza, Italy*
[5]*Managing Department, Health Care Trust, ASST Monza, Monza, Italy*
[6]*IRCCS Istituto Centro San Giovanni di Dio Fatebenefratelli, Brescia, Italy*

Correspondence
Ester di Giacomo,
Email: ester.digiacomo@unimib.it

ORCID

Ester di Giacomo https://orcid.org/0000-0001-5433-1268

REFERENCES

1. Istituto, Superiore, Sanità. Survey nazionale sul contagio COVID-19 nelle strutture residenziali e sociosanitarie. https://www.epicentro.iss.it/coronavirus/pdf/sars-cov-2-survey-rsa-rapporto-3.pdf. Accessed April 6, 2020.
2. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed.Washington, DC: APA; 2013.
3. World Health Organization. Preparedness, prevention and control of COVID-19 in prisons and other places of detention. http://www.euro.who.int/en/health-topics/health-determinants/prisons-andhealth/publications/2020/preparedness,-prevention-and-control-of-covid-19-in-prisons-and-otherplaces-of-detention. Accessed March 15, 2020.
4. Morandi A, Lucchi E, Turco R, et al. Delirium superimposed on dementia: a quantitative and qualitative evaluation of informal caregivers and health care staff experience. *J Psychosom Res*. 2015;79(4):272-280.
5. Network SIG. Delirium: patient booklet, 2020. https://www.bgs.org.uk/resources/coronavirus-managing-delirium-in-confirmed-and-suspectedcases. Accessed March 16, 2020.
6. Network SIG. Risk reduction and management of delirium, Podcast, 2019.
7. NICE. Delirium prevention, diagnosis and management guideline (updated 2019). https://www.nice.org.uk/guidance/cg103 Accessed March 18, 2020.
8. NICE. Violence and aggression: short-term management in mental health, health and community settings, 2015. https://www.nice.org.uk/guidance/ng10. Accessed March 17, 2020.
9. Cochrane. Coronavirus—COVID-19: evidence relevant to critical care. https://iran.cochrane.org/news/coronavirus-covid-19-evidence-relevant-critical-care. Accessed March 24, 2020.
10. Bellelli G, Morandi A, Davis DH, et al. Validation of the 4AT, a new instrument for rapid delirium screening: a study in 234 hospitalised older people. *Age Ageing*. 2014;43(4):496-502.
11. MacLullish A, Ryan T, Cash E. 4AT assessment test of delirium and cognitive impairment. https://www.the4at.com/. Accessed March 17, 2020.

12. LaHue SC, James TC, Newman JC, Esmaili AM, Ormseth CH, Ely EW. Collaborative delirium prevention in the age of COVID-19. *J Am Geriatr Soc*. 2020. https://doi.org/10.1111/jgs.16480.
13. di Giacomo E, Colmegna F, Santorelli M, et al. Il delirium nel paziente COVID-19+ "giovane" (<65 anni): indicazioni cliniche preliminari. *Riv Psichiatr*. 2020; in press.
14. NHS. COVID-19 and palliative, end of life and bereavement care in secondary care. Role of the specialty and guidance to aid care. https://apmonline.org/wp-content/uploads/2020/03/COVID-19-and-Palliative-End-of-Lifeand-Bereavement-Care-22-March-2020.pdf. Accessed March 22, 2020.