

Journée Filière CERVEAU

Jeudi 1^{er} octobre 2026

8h30 – 16h30

Espace Bellegarde – 129 avenue du Parc – 73190 Challes-les-Eaux

CONFUSION

Laurent Vercueil,

Explorations Fonctionnelles du Système Nerveux (CHU Grenoble Alpes)

Laboratoire de Psychologie & Neurocognition (Université Grenoble Alpes)

lvercueil@chu-grenoble.fr

Liens d'intérêt

- Orateur ponctuel : BIAL, UCB PHARMA, JAZZ PHARMA

Plan de la présentation/objectifs

1. Définition de la confusion

Où l'on revient brièvement sur les débats terminologiques de la confusion/delirium

2. Mécanique de la confusion

Où l'on comprend comment les mécanismes de l'éveil conditionnent l'accès aux ressources attentionnelles

3. Clinique de la confusion

Où l'on saisit les nuances cliniques de la confusion

4. Importance de la confusion

Où l'on souligne la place de la confusion dans le domaine de l'urgence

5. Prise en soin de la confusion

Où l'on survole les principes de la prise en soin, 17 ans après les recos de l'HAS

6. Pas la confusion

Où l'on mentionne les principaux diagnostics différentiels

1. Définition
2. Mécanique
3. Clinique
4. Importance
5. Prise en soin
6. Pas la confusion

Qu'est-ce que la confusion ?

Intensive Care Med (2020) 46:1020–1022
<https://doi.org/10.1007/s00134-019-05907-4>

WHAT'S NEW IN INTENSIVE CARE

Updated nomenclature of delirium and acute encephalopathy: statement of ten Societies

Arjen J. C. Slooter^{1*}, Wim M. Otte², John W. Devlin^{3,4}, Rakesh C. Arora^{5,6}, Thomas P. Bleck⁷, Jan Claassen⁸, Matthew S. Duprey^{3,4}, E. Wesley Ely^{9,10}, Peter W. Kaplan¹¹, Nicola Latronico¹², Alessandro Morandi^{13,14}, Karin J. Neufeld¹⁵, Tarek Sharshar¹⁶, Alasdair M. J. MacLulich¹⁷ and Robert D. Stevens¹⁸

Patients with an acute illness frequently acquire an acute, global disturbance in cognition variably referred to as delirium, encephalopathy, acute confusional state, acute brain dysfunction, acute brain failure, and altered mental status

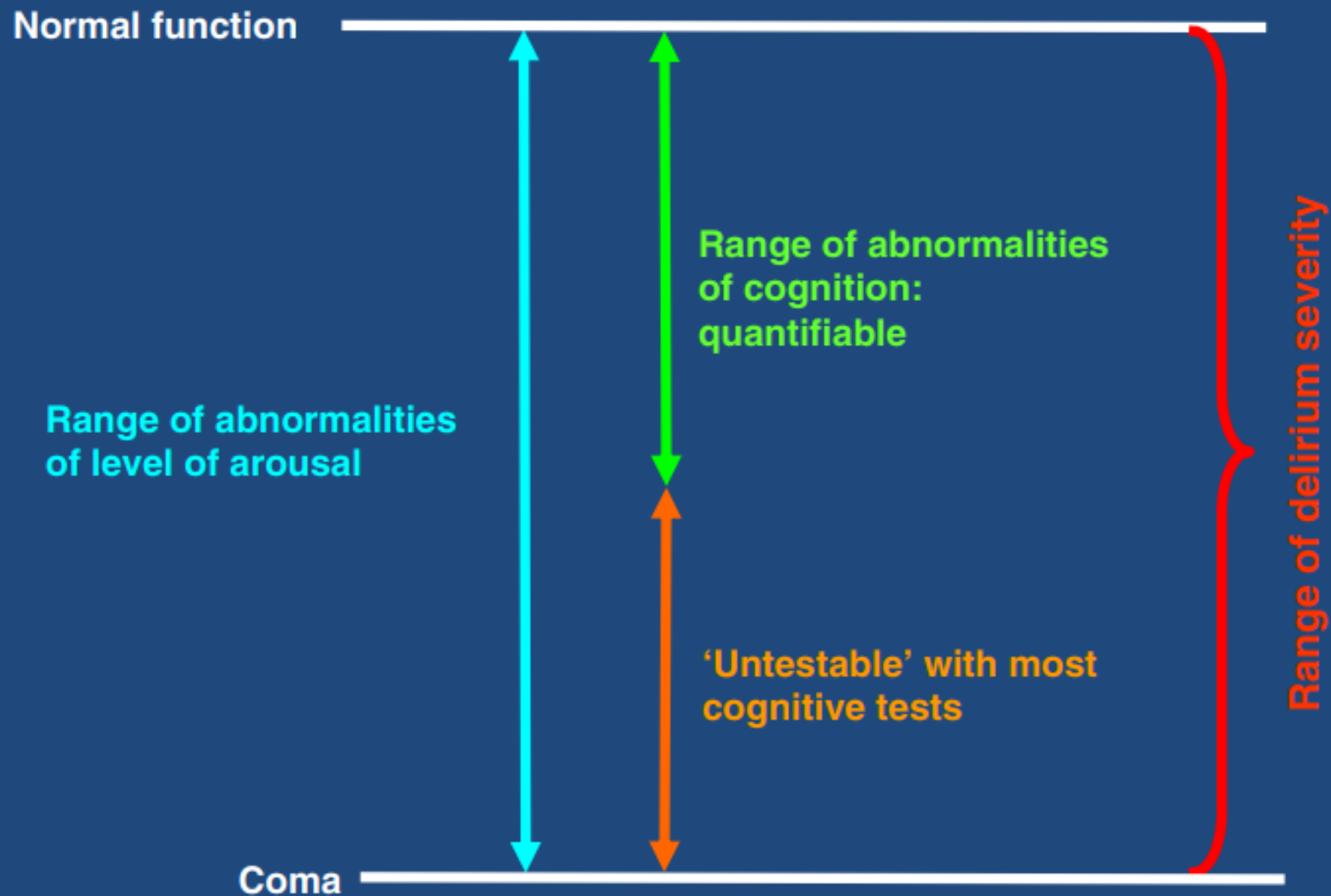
journals on clinical neurology, neurosciences, or general or internal medicine published significantly more articles with 'encephalopathy' in the title, whereas journals associated with geriatrics, gerontology, psychiatry, psychology, intensive-care medicine, or anaesthesiology published significantly more delirium-titled articles (P<0.001)

Box: Recommendations for the nomenclature of delirium, acute encephalopathy, and related terms

1. The term *acute encephalopathy* refers to a rapidly developing (over less than 4 weeks, but usually within hours to a few days) pathobiological process in the brain. **This is a preferred term**
2. *Acute encephalopathy* can lead to a clinical presentation of subsyndromal delirium, delirium, or in case of a severely decreased level of consciousness, coma; all representing a change from baseline cognitive status
3. The term *delirium* refers to a clinical state characterized by a combination of features defined by diagnostic systems such as the DSM-5. Delirium according to the DSM-5 is defined if criterium A-E are fulfilled: A. Disturbance in attention (i.e., reduced ability to direct, focus, sustain, and shift attention) and awareness (reduced orientation to the environment). B. The disturbance develops over a short period of time (usually hours to a few days) represents a change from baseline attention and awareness, and tends to fluctuate in severity during the course of the day. C. An additional disturbance in cognition (e.g., memory deficit, disorientation, language, visuospatial ability, or perception). D. The disturbances in criteria A and C are not explained by another pre-existing, established, or evolving neurocognitive disorder, and do not occur in the context of a severely reduced level of arousal, such as coma. E. There is evidence from the history, physical examination, or laboratory findings that the disturbance is a direct physiologic consequence of another medical condition, substance intoxication or withdrawal (i.e. because of a drug of abuse medication), or exposure to a toxin, or is because of multiple etiologies. **This is a preferred term**
4. The term *coma* refers to a clinical state of severely depressed responsiveness defined by diagnostic systems such as the GCS or FOUR score. **This is a preferred term**
5. The term *acute confusional state* **should not be used** in addition to the terms delirium and acute encephalopathy
6. The term *acute brain dysfunction* **should not be used** in addition to the terms delirium and acute encephalopathy
7. The term *acute brain failure* **should not be used** in addition to the terms delirium and acute encephalopathy
8. The term *altered mental status* is not synonymous with delirium and **should not be used**

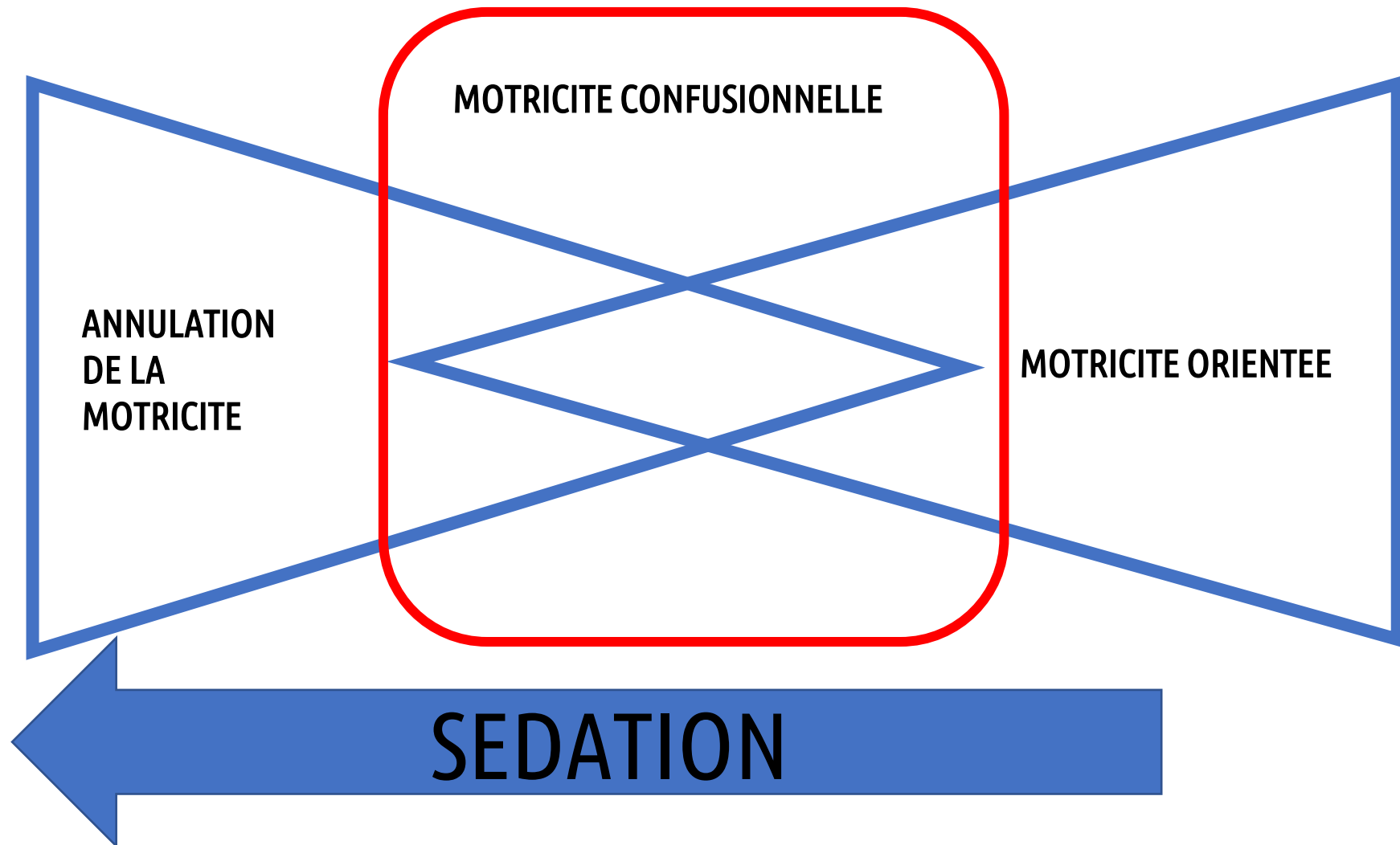
1. Définition	Qu'est-ce que la confusion ?	
2. Mécanique	• Syndrome neuropsychiatrique sévère caractérisé par la survenue aiguë d'un déficit de l'éveil, de l'attention et de la conscience	
3. Clinique	DSM-5 A. Disturbance in <u>attention</u> (i.e., reduced ability to direct, focus, sustain, and shift attention) and <u>awareness</u> (reduced <i>orientation to the environment</i>). B. The disturbance develops over a short period of time (usually hours to a few days), <i>represents an acute change from baseline attention and awareness</i>, and tends to fluctuate in severity during the course of a day. C. An <u>additional disturbance in cognition</u> (e.g. memory deficit, disorientation, language, visuospatial ability, or perception). <i>D. The disturbances in Criteria A and C are not better explained by a pre-existing, established or evolving neurocognitive disorder and do not occur in the context of a severely reduced level of arousal such as coma.</i> E. There is evidence from the history, physical examination or laboratory findings that the disturbance is <u>a direct physiological consequence of another medical condition, substance intoxication or withdrawal</u> (i.e. <i>due to a drug of abuse or to a medication</i>), or <i>exposure to a toxin, or is due to multiple etiologies.</i>	DSM-IV A. Disturbance of consciousness (i.e. reduced clarity of awareness of the environment) with reduced ability to focus, sustain or shift attention. B. A change in cognition or the development of a perceptual disturbance that is not better accounted for by a pre-existing, established or evolving dementia. C. The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day D. There is evidence from the history, physical examination or laboratory findings that the disturbance is caused by the direct physiological consequences of a general medical condition.
4. Importance		
5. Prise en soin		
6. Pas la confusion	DSM-IV, <i>Diagnostic and Statistical Manual of Mental Disorders</i>, fourth edition; DSM-5, <i>Diagnostic and Statistical Manual of Mental Disorders</i>, fifth edition. ^aChanges in DSM-5 from DSM-IV shown in <i>italics</i>.	

1. Définition
2. Mécanique
3. Clinique
4. Importance
5. Prise en soin
6. Pas la confusion

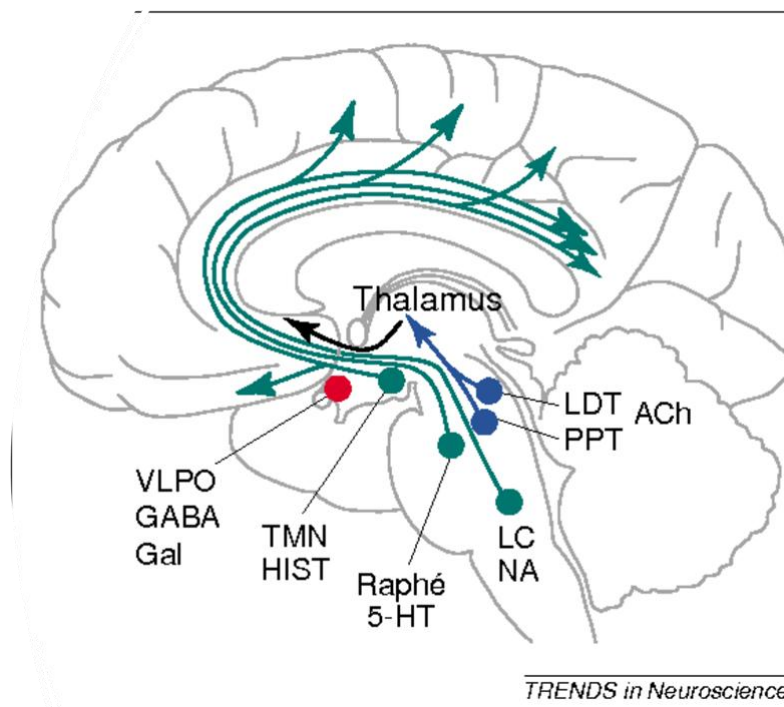


1. Définition
2. Mécanique
3. Clinique
4. Importance
5. Prise en soin
6. Pas la confusion

Comportement moteur & sédation

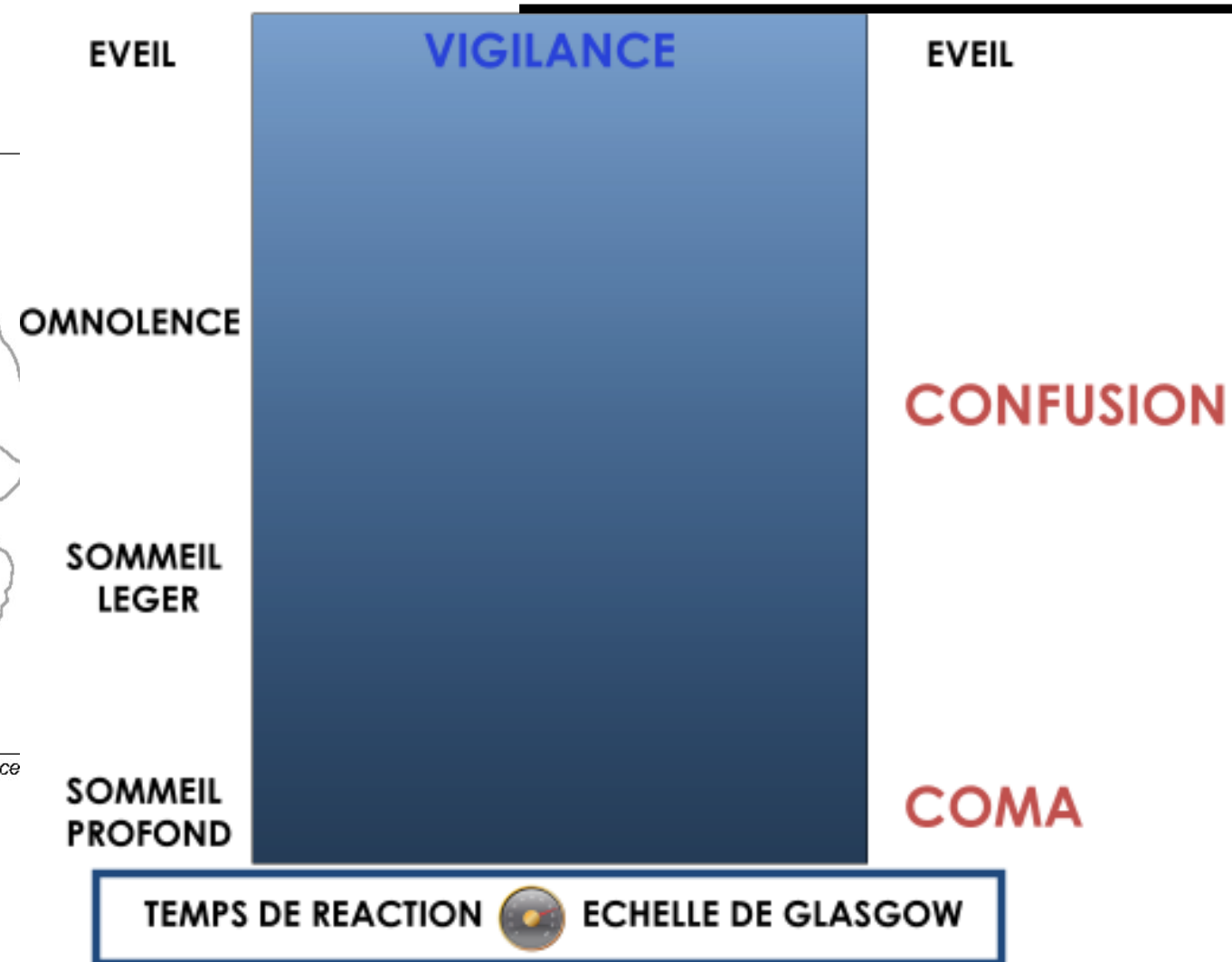


- 1. Définition
- 2. Mécanique
- 3. Clinique
- 4. Importance
- 5. Prise en soin
- 6. Pas la confusion



TRENDS in Neuroscience

L'éveil pour le monitoring de l'environnement



1. Définition

2. Mécanique

3. Clinique

4. Importance

5. Prise en soin

6. Pas la confusion

L'attention pour la capture des évènements

Dynamic Switching

The diagram illustrates the dynamic switching between two primary brain networks. At the top, a brain model shows the **Saliency Network** (teal) and the **Locus Coeruleus** (green). The **Saliency Network** includes regions dACC, rAI, and IAI. The **Locus Coeruleus** is shown as a small green structure. Below, two brain models represent the **Dorsal Attention Network** (red) and the **Default Mode Network** (purple). The **Dorsal Attention Network** includes rFEF, IFEF, rSPL, and ISPL. The **Default Mode Network** includes Precuneus, mPFC, rAG, PCC, and IAG. A dashed green arrow labeled "Anticorrelation" connects the two networks. The **Dorsal Attention Network** is associated with "Environmentally Directed Processes", and the **Default Mode Network** is associated with "Internally Directed and Self-inferential Processes".

Environmentally Directed Processes

Internally Directed and Self-inferential Processes

RESSOURCES ATTENTIONNELLES

The diagram shows a vertical stack of blue jugs representing attentional resources. The stack is divided into four horizontal sections corresponding to different states of consciousness: **EVEIL** (top), **SOMNOLENCE**, **SOMMEIL LEGER**, and **SOMMEIL PROFOND** (bottom). The number of jugs decreases from 3 in the **EVEIL** section to 0 in the **SOMMEIL PROFOND** section. The **CONFUSION** and **COMA** states are indicated by red text on the right side of the diagram.

EVEIL

SOMNOLENCE

SOMMEIL LEGER

SOMMEIL PROFOND

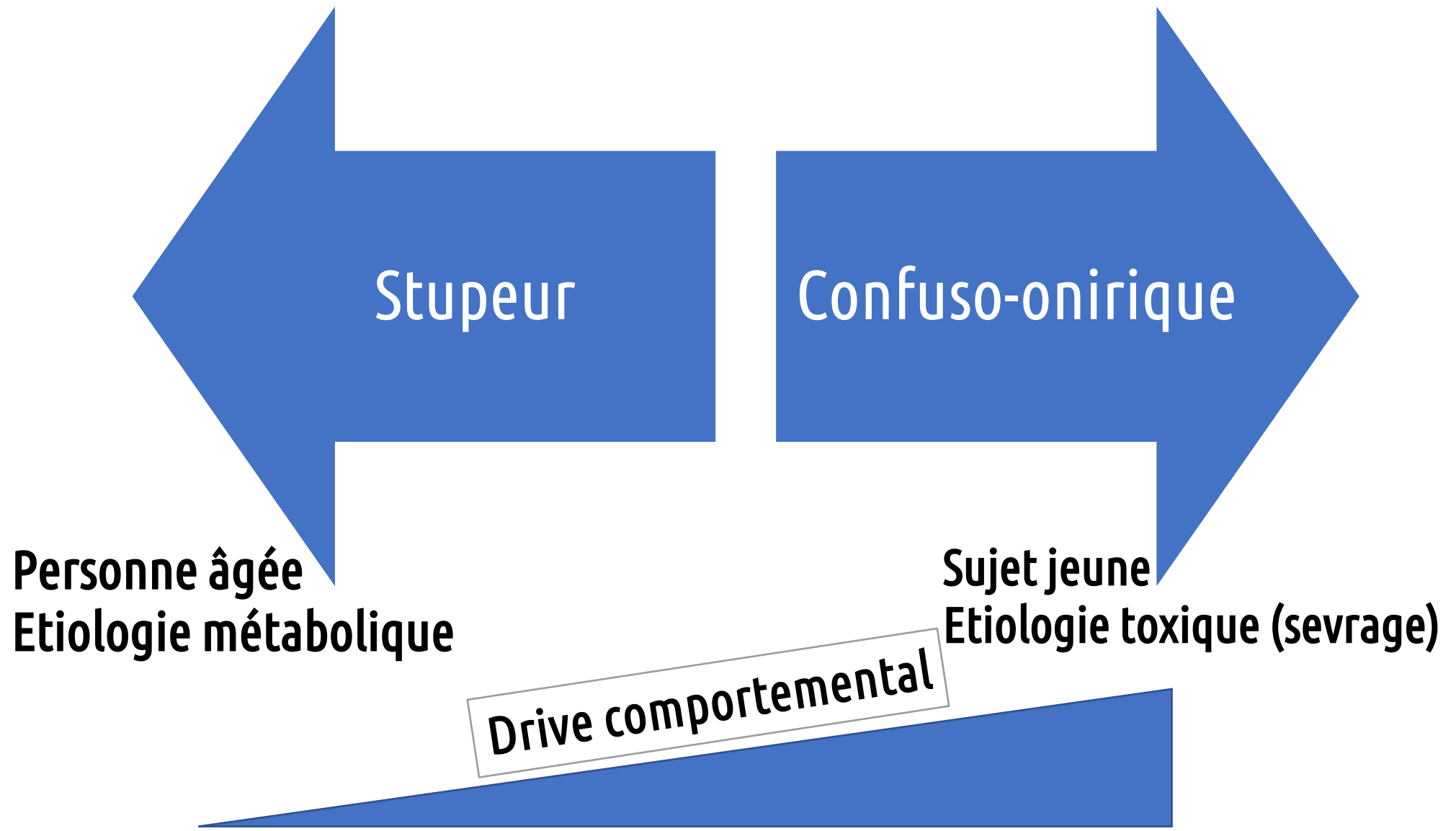
CONFUSION

COMA

1. Définition	Accès au contenu conscient The diagram illustrates the Global Workspace model. At the center is a 'Global Workspace' represented by a dense network of interconnected nodes. Surrounding this central workspace are four main functional areas, each indicated by a large arrow pointing towards the center: 'Evaluative Systems (VALUE)' at the top, 'Attentional Systems (FOCUSING)' on the right, 'Motor systems (FUTURE)' at the bottom, and 'Perceptual systems (PRESENT)' on the left. Additionally, a 'Long-Term Memory (PAST)' system is shown on the far left, with an arrow pointing into the workspace. The entire network is enclosed within a series of concentric dotted circles. This diagram shows the levels of consciousness on a vertical scale, represented by a large triangle. The top of the triangle is labeled 'CONSCIENCE' in red. Inside the triangle are seven blue jugs, with the number of jugs decreasing from top to bottom: three at the top, two in the middle, and one at the bottom. To the left of the triangle, the levels are labeled in French: 'EVEIL' (top), 'SOMNOLENCE', 'SOMMEIL LEGER', and 'SOMMEIL PROFOND' (bottom). To the right of the triangle, the corresponding English terms are listed: 'EVEIL', 'CONFUSION', and 'COMA' (at the very bottom). The background of the triangle transitions from light blue at the top to dark blue at the bottom.
2. Mécanique	
3. Clinique	
4. Importance	
5. Prise en soin	
6. Pas la confusion	

1. Définition
2. Mécanique
3. Clinique
4. Importance
5. Prise en soin
6. Pas la confusion

Aux principes cliniques de la confusion



1. Définition	Méthode d'évaluation de la confusion (CAM, Confusion Assessment Method) pour le diagnostic de la confusion*	
2. Mécanique	Caractéristique	Évaluation†
3. Clinique	Signes nécessaires	
	Apparition aiguë et évolution fluctuante	Montrée par des réponses positives aux questions suivantes: "Est-ce que l'état mental du patient a changé brusquement par rapport à son état de base ?" "Est-ce que le comportement anormal a fluctué au cours de la journée (c'est-à-dire a eu tendance à apparaître puis disparaître ou à augmenter et diminuer en gravité) ?"
	Inattention	Démontrée par une réponse positive à la question suivante: "Le patient avait-il des difficultés à concentrer son attention (p. ex., était-il facilement distrait ou avait-il du mal à suivre ce qui se disait)?"
	L'une des caractéristiques suivantes requises	
	Désorganisation de la pensée	Démontrée par une réponse positive à la question suivante: "La pensée du patient était-elle désorganisée ou incohérente (p. ex., comme en témoignerait une conversation non pertinente, des idées non claires ou illogiques ou un passage imprévisible d'un sujet à l'autre)?"
4. Importance	Niveau de conscience altéré	Montré par toute autre réponse que "alerte" à la question suivante: "Dans l'ensemble, comment évalueriez-vous le niveau de conscience de ce patient?" • Normal = alerte • Hyperalerte = vigilant • Somnolent, facilement éveillable = léthargique • Difficile à éveiller = stupeur • Ne peut être réveillé = coma
5. Prise en soin	*Le diagnostic de confusion nécessite la présence des 2 premiers signes <i>plus</i> l'un des deux seconds signes.	
6. Pas la confusion	†Cette information est habituellement obtenue d'un membre de la famille ou d'une infirmière.	
	Inouye SK, van Dyck CH, Alessi CA, Balkin S, Siegal AP, Horwitz RI. Clarifying confusion: the confusion assessment method. A new method for detection of delirium. <i>Ann Intern Med.</i> 1990;113(12):941-948. doi:10.7326/0003-4819-113-12-941	
	Depuis le Manuel Merck	

1. Définition

2. Mécanique

3. Clinique

4. Importance

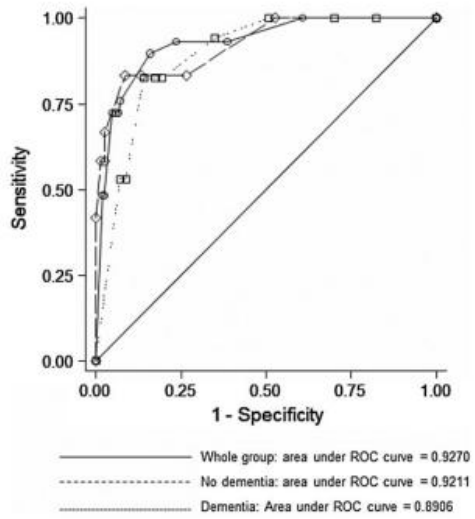
5. Prise en soin

6. Pas la confusion

G. Bellelli et al.
Age and Ageing 2014; 43: 496–502
doi: 10.1093/ageing/afu021
Published electronically 2 March 2014
© The Author 2014. Published by Oxford University Press on behalf of the British Geriatrics Society.
This is an Open Access article distributed under the terms of the Creative Commons Attribution License
(http://creativecommons.org/licenses/by/3.0/), which permits unrestricted reuse, distribution, and
reproduction in any medium, provided the original work is properly cited.

Validation of the 4AT, a new instrument for rapid delirium screening: a study in 234 hospitalised older people

GIUSEPPE BELLELLI^{1,2}, ALESSANDRO MORANDI^{2,3}, DANIEL H.J. DAVIS^{4,5}, PAOLO MAZZOLA¹, RENATO TURCO^{2,3}, SIMONA GENTILE^{2,3}, TRACY RYAN⁶, HELEN CASH⁶, FABIO GUERINI^{2,3}, TIZIANA TORPILLIES^{2,3}, FRANCESCO DEL SANTO^{2,3}, MARCO TRABUCCHI^{2,7}, GIORGIO ANNONI¹, ALASDAIR M.J. MACLULLICH^{5,6}



Cut-off =>4	sensitivity	specificity	LR+	LR-	AUROC
Whole cohort	89.7%	84.1%	5.624	0.123	0.927
No dementia					
subgroup	83.3%	91.3%	9.615	0.183	0.921
Dementia subgroup	94.1%	64.9%	2.682	0.091	0.891

LR+ and LR- denotes positive and negative Likelihood ratio, respectively. AUROC denotes the Area Under the Curve



Test d'évaluation du délirium et des troubles cognitifs

[1] ÉTAT DE CONSCIENCE

Cela inclut les patients qui peuvent être nettement somnolents (par exemple, difficiles à réveiller et/ou visiblement endormis lors de l'évaluation) ou agités/hyperactifs. Observez le patient. S'il est endormi, essayez de le réveiller en lui parlant ou en touchant doucement son épaule. Demandez au patient de dire son nom et son adresse pour aider l'évaluation.

Normal (alerte, mais pas agité, tout au long de l'évaluation)	0
Somnolence légère <10 secondes après le réveil, puis normal	0
Clairement anormal	4

[2] AMT4

Âge, date de naissance, endroit (nom de l'hôpital ou du bâtiment), année courante.

Aucune erreur	0
1 erreur	1
2 erreurs ou plus/ne peut être testé	2

[3] ATTENTION

Demandez au patient : « Pouvez-vous me dire les mois de l'année dans l'ordre inverse, en commençant par décembre. » Pour aider à la compréhension, il est permis de dire une seule fois : « quel est le mois avant décembre? »

Mois de l'année à l'envers	Réussit à nommer 7 mois ou plus	0
	Commence, mais réussit <7 mois ou refuse de commencer	1
	Ne peut être testé (ne peut pas commencer, car ne se sent pas bien, somnolent ou inattentif)	2

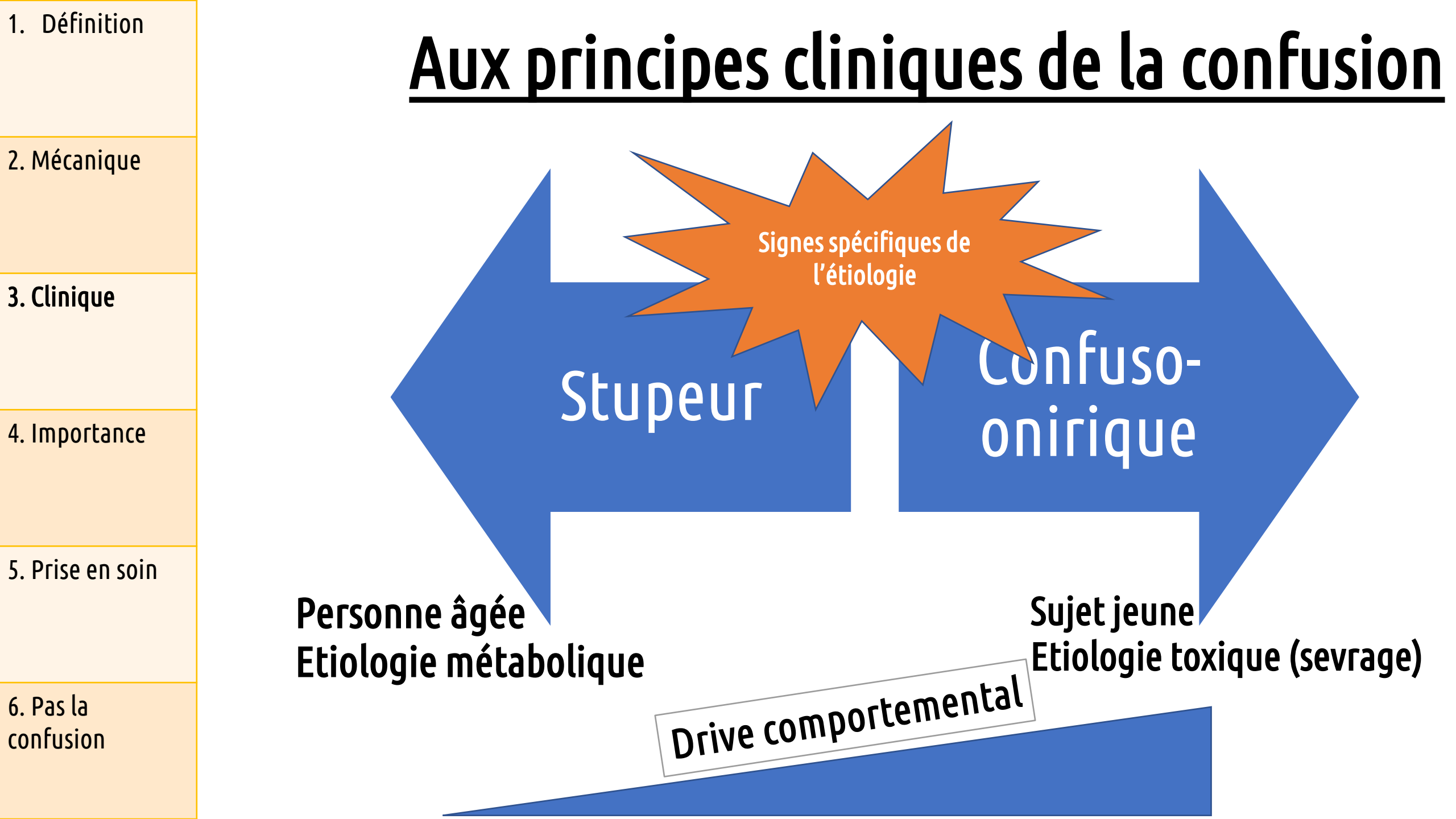
[4] CHANGEMENT AIGU OU ÉVOLUTION FLUCTUANTE

Preuve de changements significatifs ou de fluctuation de l'état de conscience, cognition, autre fonction mentale (ex. paranoïa, hallucinations) apparus au cours des 2 dernières semaines et encore apparents dans les dernières 24 heures.

Non	0
Oui	4

4 ou plus : délirium possible +/- troubles cognitifs
1-3 : troubles cognitifs possibles
0 : délirium ou troubles cognitifs sévères peu probable (mais délirium encore possible si information incomplète à [4])

SCORE DU 4AT



1. Définition

2. Mécanique

3. Clinique

4. Importance

5. Prise en soin

6. Pas la confusion

Geriatric Medicine Research Collaborative *BMC Medicine* (2019) 17:229
<https://doi.org/10.1186/s12916-019-1458-7>

BMC Medicine

RESEARCH ARTICLE

Open Access

Delirium is prevalent in older hospital inpatients and associated with adverse outcomes: results of a prospective multi-centre study on World Delirium Awareness Day

Geriatric Medicine Research Collaborative

Check for updates

Specialty	Recognised delirium (%)	Unrecognised delirium (%)
Acute medicine	~6	~10
Geriatric medicine	~10	~12
Other medicine	~2	~8
Stroke	~4	~3
General and other surgery	0	~5*
Orthopaedic surgery	~2	~13*

Age and Ageing 2020; 49: 352–360
doi: 10.1093/ageing/afaa040
Published electronically 2 April 2020

© The Author(s) 2020. Published by Oxford University Press on behalf of the British Geriatrics Society. This is an Open Access article distributed under the terms of the Creative Commons Attribution License (<http://creativecommons.org/licenses/by/4.0/>), which permits unrestricted reuse, distribution, and reproduction in any medium, provided the original work is properly cited.

SYSTEMATIC REVIEW

The consistent burden in published estimates of delirium occurrence in medical inpatients over four decades: a systematic review and meta-analysis study

KATE GIBB^{1,2}, ANNA SEELEY^{1,3}, TERRY QUINN⁴, NAJMA SIDDIQI⁵, SUSAN SHENKIN⁶, KENNETH ROCKWOOD^{1,7}, DANIEL DAVIS^{1,2,3}

1. Définition
2. Mécanique
3. Clinique
4. Importance
5. Prise en soin
6. Pas la confusion

Facteurs prédisposants

- Age
- Trouble cognitif
- Comorbidités
- Troubles mentaux
- Alcool
- Dénutrition
- Isolement sensoriel



vs

Facteurs précipitants

- Affection médicale aiguë
- Traumatisme
- Chirurgie
- Déshydratation
- Stress psychologique
- Intoxication



1. Définition

2. Mécanique

3. Clinique

4. Importance

5. Prise en soin

6. Pas la confusion



MDPI

www.nature.com/scientificreports

Brief Report

Aging and Cerebral Glucose Metabolism: ¹⁸F-FDG-PET/CT Reveals Distinct Global and Regional Metabolic Changes in Healthy Patients

Robert Christopher Subtirelu¹, Eric Michael Teichner^{1,2}, Yvonne Su¹, Omar Al-Daoud¹, Milan Patel¹, Shiv Patil^{1,2}, Milo Writer¹, Thomas Werner¹, Mona-Elisabeth Revheim^{3,4}, Poul Flemming Høilund-Carlsen^{5,6} and Abass Alavi^{1,*}

OPEN

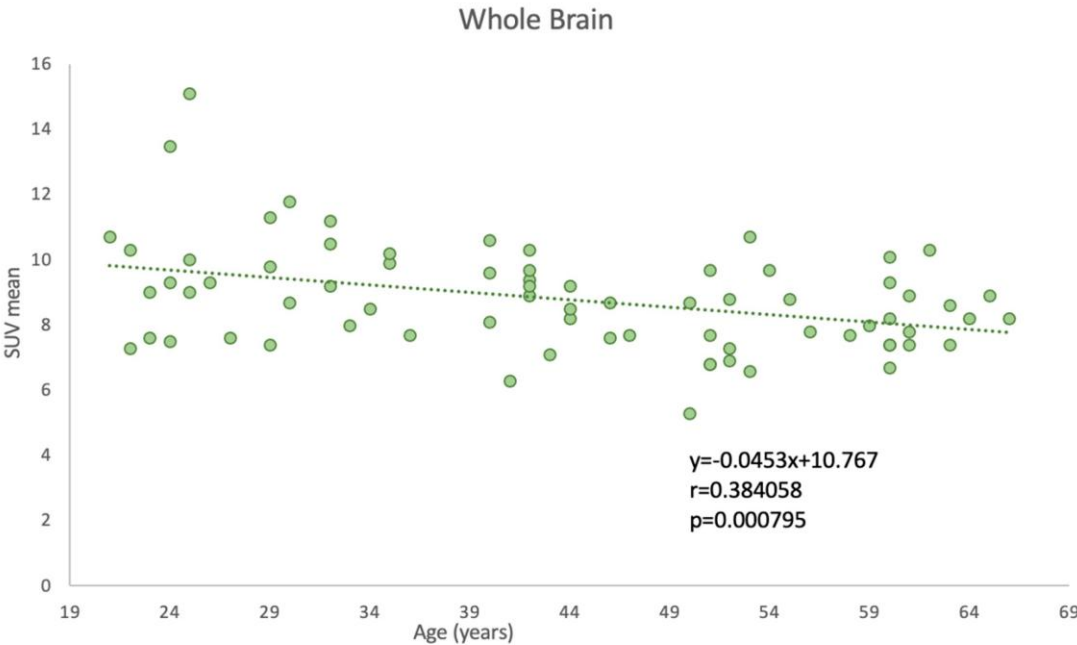
Longitudinal effects of aging on ¹⁸F-FDG distribution in cognitively normal elderly individuals

Kenji Ishibashi¹, Airin Onishi¹, Yoshinori Fujiwara², Keiichi Oda^{1,3}, Kiichi Ishiwata^{1,4,5} & Kenji Ishii¹

Received: 29 January 2018
Accepted: 18 July 2018
Published online: 01 August 2018

Previous studies of aging effects on fluorine-18-labeled fluorodeoxyglucose (¹⁸F-FDG) distribution have

Whole Brain



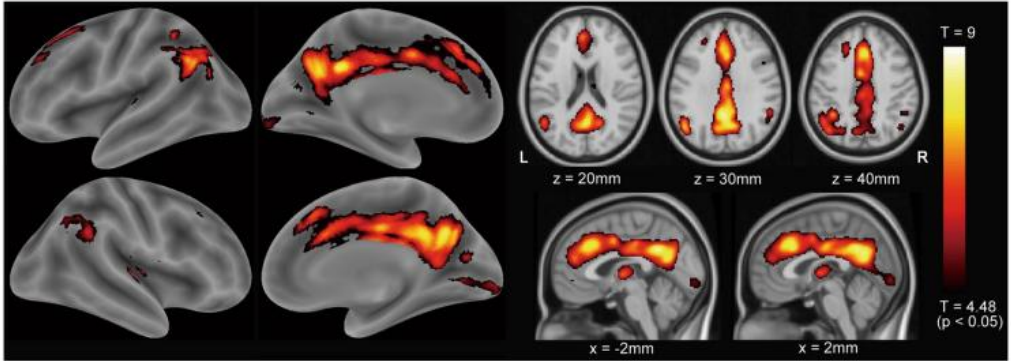


Figure 2. Results of the voxel-wise analysis: effects of aging on ¹⁸F-FDG distribution. To assess the effects of aging and apolipoprotein E ε4 genotype, a voxel-wise analysis was performed on all participants using a two-way repeated-measures analysis of variance with two time points (baseline or second positron emission tomography scan) × two conditions (presence or absence of apolipoprotein E ε4 genotype). Sex and MMSE scores were specified as nuisance covariates. The aging effects on ¹⁸F-FDG distribution were significant at *p* < 0.05, familywise error rate-corrected. The significant clusters extended to the anterior cingulate cortex, posterior cingulate cortex/precuneus, and lateral parietal cortex. The hot scale represents the magnitude of the *p* and *t* values. ¹⁸F-FDG: fluorine-18-labeled fluorodeoxyglucose, R: right, L: left, MMSE: Mini-Mental State Examination.

1. Définition	Les tâches les plus coûteuses sont les premières touchées Tâches frontales +++++ • Contrôle exécutif : inhibition <i>Différer une action (distractibilité, etc..), planifier une séquence, (go no go)</i> • Contrôle cognitif : discrimination <i>Identifier correctement un stimulus (augmentée dans les situations d'ambiguïté perceptive)</i> <i>Métacognition</i>
2. Mécanique	
3. Clinique	
4. Importance	
5. Prise en soin	
6. Pas la confusion	

1. Définition	Privilégier la recherche et le traitement de la cause ++++ • Causes médicales générales (fécalome, globe, douleurs (IDM), fièvre, etc...) • Corrections métaboliques, toxiques (prélèvements ++++), arrêt médicaments non vitaux • Causes curables +++ (HSV, etc..) • Hydratation, apport calorique, apport oxygène... • Désambiguïsation de l'environnement : communication, lumière, simplification de l'environnement • Traitements médicaux : si agitation et mise en danger seulement
2. Mécanique	
3. Clinique	
4. Importance	
5. Prise en soin	
6. Pas la confusion	

1. Définition
2. Mécanique
3. Clinique
4. Importance
5. Prise en soin
6. Pas la confusion

ORIGINAL ARTICLE

Haloperidol for the Treatment of Delirium in ICU Patients

N.C. Andersen-Ranberg, L.M. Poulsen, A. Perner, J. Wetterslev, S. Estrup, J. Hästbacka, M. Morgan, G. Citerio, J. Caballero, T. Lange, M.-B.N. Kjær, B.H. Ebdrup, J. Engstrøm, M.H. Olsen, M. Oxenbøll Collet, C.B. Mortensen, S.-O. Weber, A.S. Andreasen, M.H. Bestle, B. Uslu, H. Scharling Pedersen, L. Gramstrup Nielsen, H.C. Toft Boesen, J.V. Jensen, L. Nebrich, K. La Cour, J. Laigaard, C. Haurum, M.W. Olesen, C. Overgaard-Steensen, B. Westergaard, B. Brand, G. Kingo Vesterlund, P. Thornberg Kyhnauv, V.S. Mikkelsen, S. Hyttel-Sørensen, I. de Haas, S.R. Aagaard, L.O. Nielsen, A.S. Eriksen, B.S. Rasmussen, H. Brix, T. Hildebrandt, M. Schønemann-Lund, H. Fjeldsøe-Nielsen, A.-M. Kuivalainen, and O. Mathiesen, for the AID-ICU Trial Group*

Andersen-Ranberg NC, et al.; AID-ICU Trial Group. Haloperidol for the Treatment of Delirium in ICU Patients. N Engl J Med. 2022 Dec 29;387(26):2425-2435. doi: 10.1056/NEJMoa2211868.

1. Définition

2. Mécanique

3. Clinique

4. Importance

5. Prise en soin

6. Pas la confusion

1738 Patients with delirium were assessed for eligibility

738 Were excluded

- 427 Received an antipsychotic agent in the ICU
- 130 Had contraindication to haloperidol
- 107 Used an antipsychotic agent before hospital admission
- 102 Did not have consent provided
- 59 Could not be adequately assessed for delirium because of language barriers, deafness, or blindness
- 37 Had delirium tremens
- 11 Had involuntary admission to hospital
- 8 Had been withdrawn from active treatment

1000 Underwent randomization

510 Were assigned to receive haloperidol

9 Did not receive haloperidol and were excluded

501 Received haloperidol

10 Did not give consent or did not have consent provided by surrogate decision maker for continued data collection

491 Were included in the analysis of the primary outcome

501 Were included in the analyses of the secondary outcomes and 90-day mortality

490 Were assigned to receive placebo

4 Did not receive placebo and were excluded

486 Received placebo

14 Did not give consent or did not have consent provided by surrogate decision maker for continued data collection

472 Were included in the analysis of the primary outcome

486 Were included in the analyses of the secondary outcomes and 90-day mortality

Haloperidol
(N=510)

2.5 mg
3 times daily



Placebo
(N=490)

0.5 ml
3 times daily



Days Alive and Out of the Hospital at 90 Days

Adjusted absolute difference, 2.9 days
(95% CI, -1.2 to 7.0)
P=0.22

35.8
(95% CI, 32.9 to 38.6)

32.9
(95% CI, 29.9 to 35.8)

Haloperidol

Placebo

Death at 90 Days

Adjusted absolute difference, -6.9 percentage points
(95% CI, -13.0 to -0.6)

Adjusted relative risk, 0.84
(95% CI, 0.72 to 0.98)

36.3

43.3

Haloperidol

Placebo

Serious Adverse Reaction in ICU

Adjusted absolute difference, 0.4 percentage points
(99% CI, -1.9 to 2.7)

Adjusted relative risk, 1.20
(99% CI, 0.33 to 5.45)

2.2

1.9

Haloperidol

Placebo

Andersen-Ranberg NC, et al.; AID-ICU Trial Group. Haloperidol for the Treatment of Delirium in ICU Patients. N Engl J Med. 2022 Dec 29;387(26):2425-2435. doi: 10.1056/NEJMoa2211868.

38

1. Définition

2. Mécanique

3. Clinique

4. Importance

5. Prise en soin

6. Pas la confusion

Overall Survival

Percentage of Patients Alive

Days since Randomization

No. at Risk

	0	10	20	30	40	50	60	70	80	90
Haloperidol	501	430	391	358	349	340	332	328	327	319
Placebo	485	383	341	320	309	300	291	286	280	275

Main and Subgroup Analyses of the Primary Outcome

Subgroup	No. of Patients		Mean No. of Days Alive and Out of Hospital (95% CI)		Adjusted Mean Difference (95% or 99% CI)
	Haloperidol	Placebo	Haloperidol	Placebo	
All patients	501	486	35.8 (32.9 to 38.7)	32.9 (29.9 to 35.8)	2.9 (-1.2 to 7.0)
Motor subtype of delirium					
Hyperactive	217	216	39.3 (34.9 to 43.7)	34.9 (30.4 to 39.3)	4.4 (-4.0 to 12.7)
Hypoactive	274	256	33.0 (29.3 to 36.8)	31.2 (27.3 to 35.1)	1.6 (-5.5 to 8.7)
Age					
<69 yr	221	189	39.3 (35.2 to 43.4)	39.1 (34.5 to 43.8)	0.4 (-7.9 to 8.8)
≥69 yr	270	283	32.9 (29.0 to 36.9)	28.7 (24.9 to 32.4)	3.8 (-3.4 to 11.0)
Sex					
Male	319	314	35.6 (32.1 to 39.1)	32.4 (28.8 to 36.0)	3.4 (-3.3 to 10.0)
Female	172	158	36.2 (31.2 to 41.2)	33.8 (28.6 to 39.1)	2.0 (-7.3 to 11.2)
Admission type					
Surgical	178	149	36.9 (32.4 to 41.5)	36.9 (31.9 to 42.0)	-1.1 (-10.0 to 7.8)
Medical	313	323	35.2 (31.5 to 38.8)	31.0 (27.4 to 34.6)	4.5 (-2.3 to 11.3)
Risk factors for delirium					
Yes	308	279	37.5 (33.9 to 41.1)	33.0 (29.2 to 36.8)	4.5 (-2.2 to 11.3)
No	183	193	32.9 (28.2 to 37.6)	32.7 (27.9 to 37.4)	0.9 (-8.0 to 9.9)
SMS-ICU					
<25	383	361	38.5 (35.3 to 41.7)	35.3 (32.0 to 38.6)	2.9 (-3.2 to 9.1)
≥25	108	111	26.3 (20.3 to 32.3)	25.1 (19.0 to 31.1)	1.2 (-10.0 to 12.5)

Haloperidol (N=510)

2.5 mg 3 times daily

Placebo (N=490)

0.5 ml 3 times daily

Days Alive and Out of the Hospital at 90 Days

Adjusted absolute difference, 2.9 days (95% CI, -1.2 to 7.0) P=0.22

Group	Raw Mean No. of Days	95% CI
Haloperidol	35.8	(32.9 to 38.6)
Placebo	32.9	(29.9 to 35.8)

Death at 90 Days

Adjusted absolute difference, -6.9 percentage points (95% CI, -13.0 to -0.6)

Adjusted relative risk, 0.84 (95% CI, 0.72 to 0.98)

Group	Percentage of Patients
Haloperidol	36.3
Placebo	43.3

Serious Adverse Reaction in ICU

Adjusted absolute difference, 0.4 percentage points (99% CI, -1.9 to 2.7)

Adjusted relative risk, 1.20 (99% CI, 0.33 to 5.45)

Group	Percentage of Patients
Haloperidol	2.2
Placebo	1.9

Andersen-Ranberg NC, et al.; AID-ICU Trial Group. Haloperidol for the Treatment of Delirium in ICU Patients. N Engl J Med. 2022 Dec 29;387(26):2425-2435. doi: 10.1056/NEJMoa2211868.

38

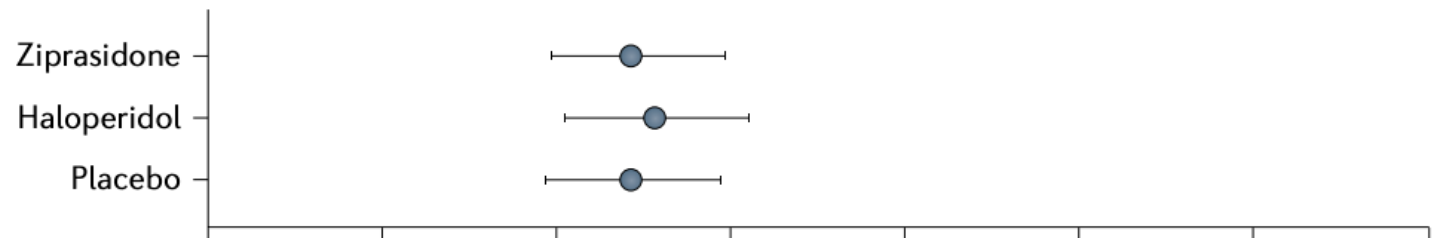
1. Définition
2. Mécanique
3. Clinique
4. Importance
5. Prise en soin
6. Pas la confusion

Privilégier la recherche et le traitement de la cause ++++

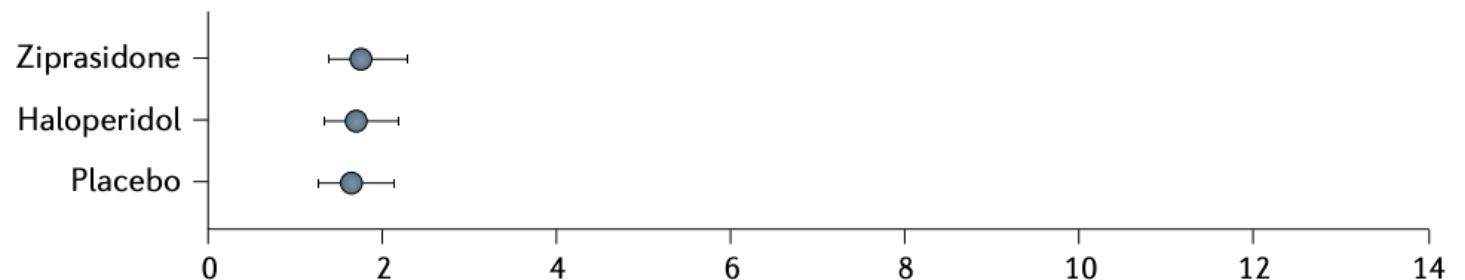
a Days alive without delirium or coma



b Days with delirium



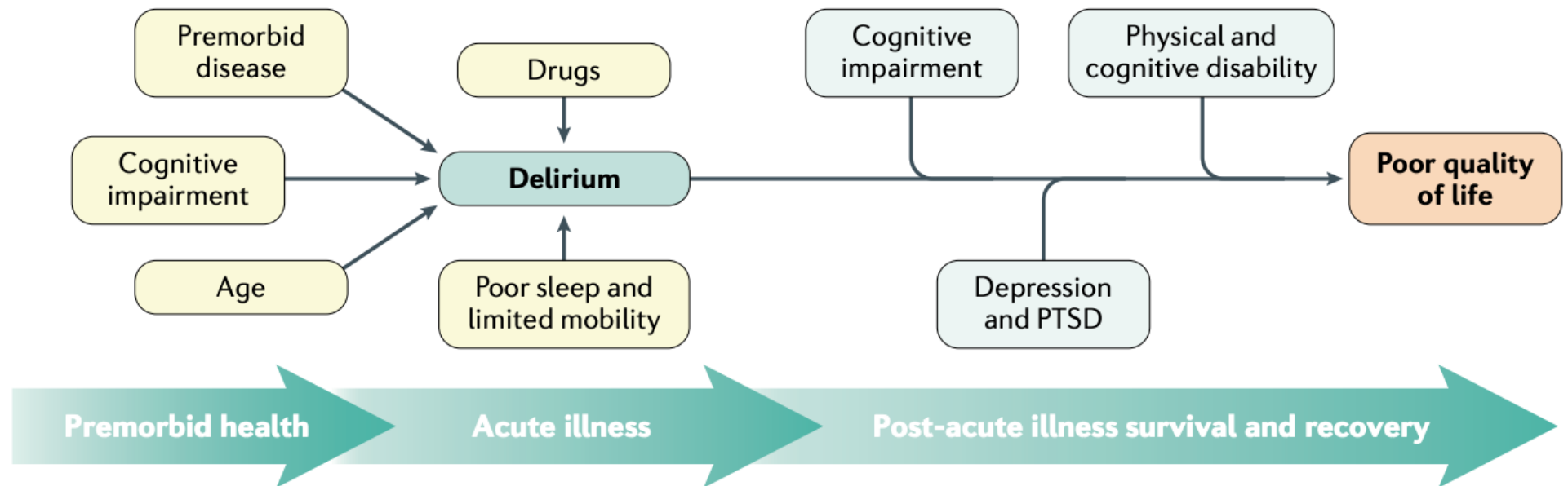
c Days with coma



Adjusted median days (95% CI)

1. Définition
2. Mécanique
3. Clinique
4. Importance
5. Prise en soin
6. Pas la confusion

Privilégier la recherche et le traitement de la cause ++++



1. Définition	Pas de la confusion/pas une encéphalopathie aiguë • Déficit neurologique focal aigu • Cécité corticale • Héminégligence gauche • Trouble praxique (Gerstmann) • Trouble du langage • Ictus amnésique • Trouble psychiatrique aigu • Trouble cognitif
2. Mécanique	
3. Clinique	
4. Importance	
5. Prise en soin	
6. Pas la confusion	

1. Définition

Cécité corticale

2. Mécanique

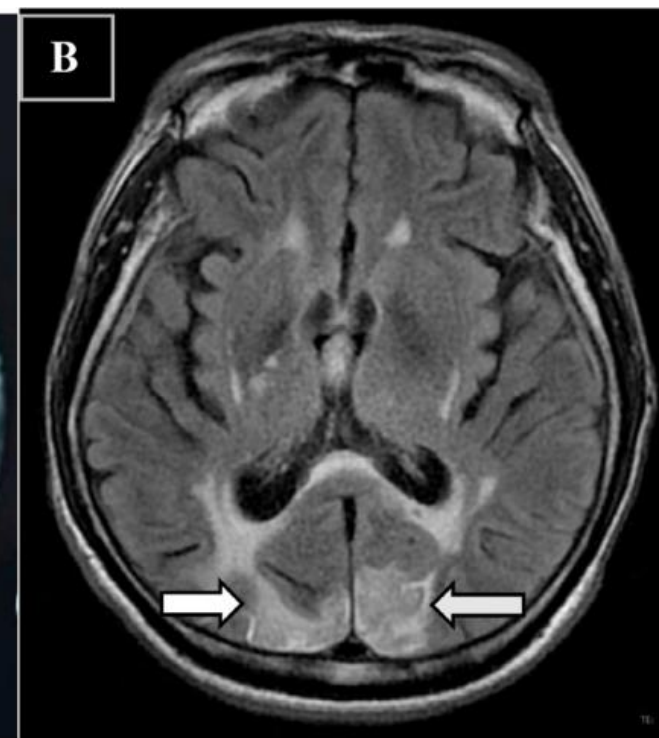
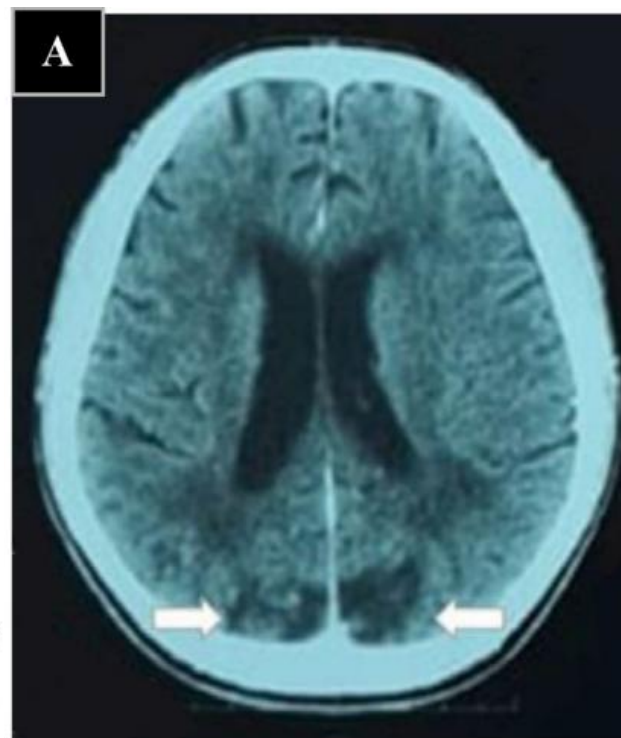
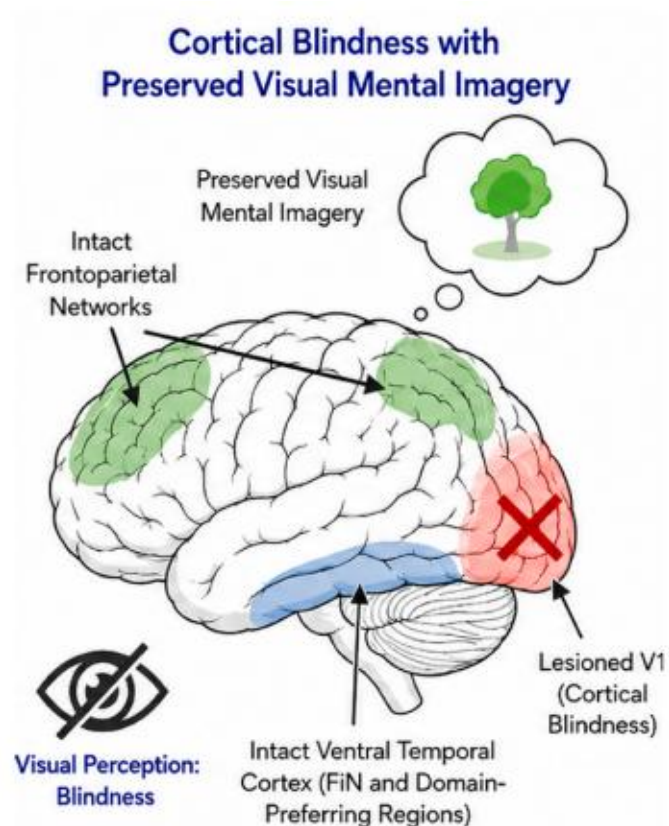
- Comportement aveugle
- Sans plainte visuelle, confabulation de la vue (Sd d'Anton)

3. Clinique

4. Importance

5. Prise en soin

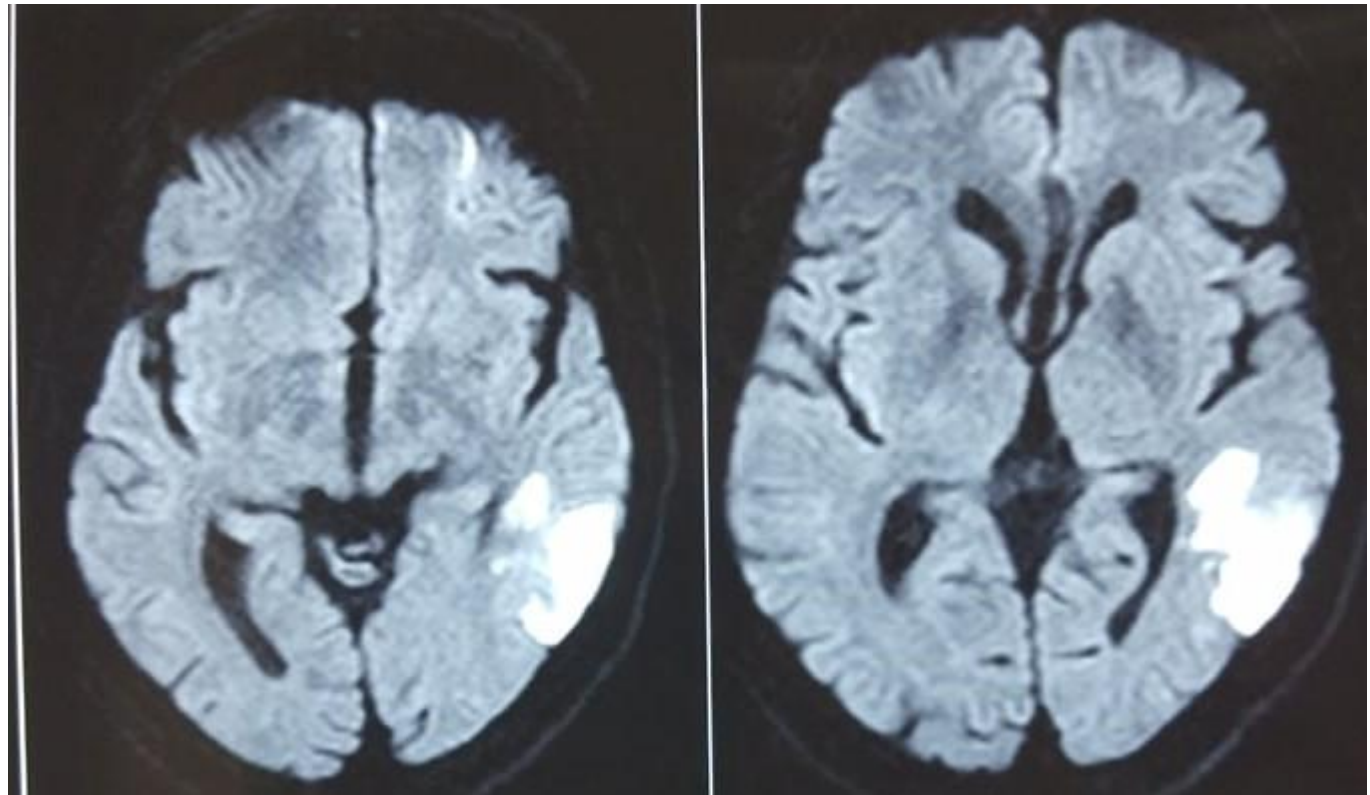
6. Pas la confusion



1. Définition
2. Mécanique
3. Clinique
4. Importance
5. Prise en soin
6. Pas la confusion

Aphasie de Wernicke

- Trouble majeur de la compréhension
- Jargonaphasie



1. Définition

2. Mécanique

3. Clinique

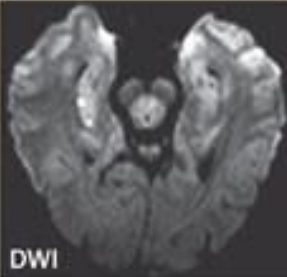
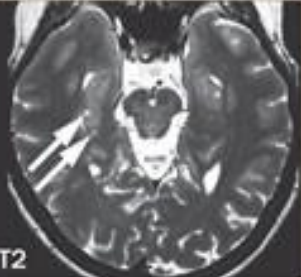
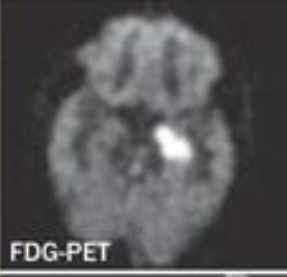
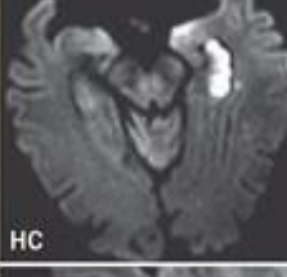
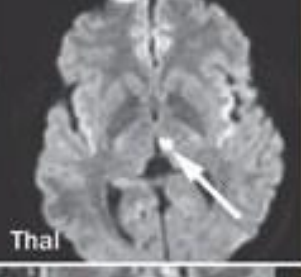
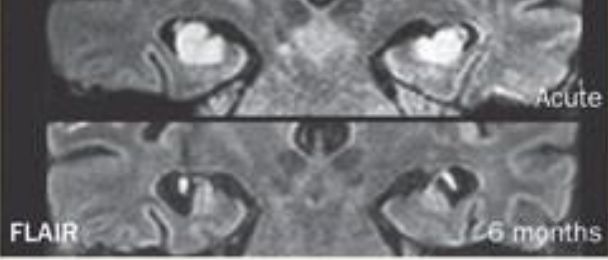
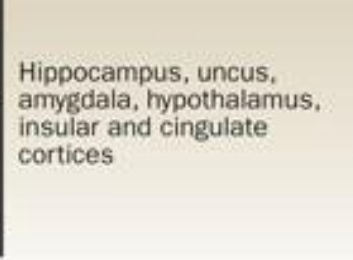
4. Importance

5. Prise en soin

6. Pas la confusion

Ictus Amnésique (Transient global amnesia)

- Amnésie antérograde sévère
- Perplexité, questionnement
- Adaptation du comportement au trouble

Syndrome	MRI		Imaging
Transient global amnesia	 DWI	 T2	Focal punctate DWI and T2 lesions in the CA1 region of the hippocampus 24–72 h after episode
Transient epileptic amnesia	 FDG-PET	 VBM	Focal hippocampal hyper-metabolism on FDG-PET VBM reveals subtle hippocampal atrophy
Strategic stroke	 HC	 Thal	DWI lesions according to vascular territory (hippocampus, thalamus, diencephalon, posterior circulation), hippocampus complete or lateral lesions
Limbic encephalitis	 FLAIR	 6 months	Hippocampus, uncus, amygdala, hypothalamus, insular and cingulate cortices

1. Définition

2. Mécanique

3. Clinique

4. Importance

5. Prise en soin

6. Pas la confusion

Trouble psychiatrique aigu

- Trouble du comportement, du discours
- Pas d'altération neurologique des fonctions instrumentales

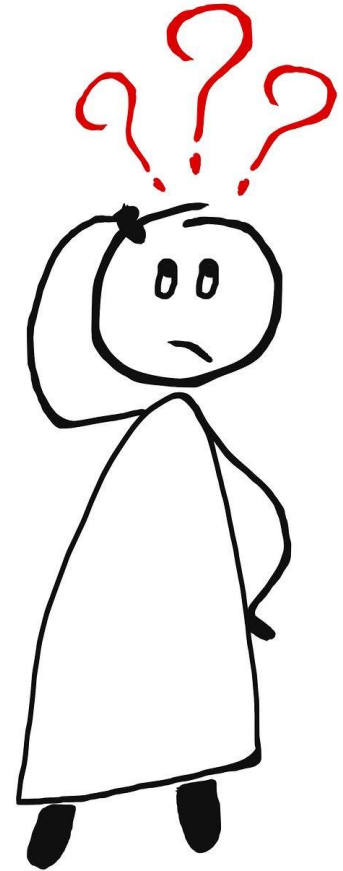


ATTENTION / facteur majeur de vulnérabilité à la confusion (association fréquente ++++)

1. Définition
2. Mécanique
3. Clinique
4. Importance
5. Prise en soin
6. Pas la confusion

Trouble neurocognitif majeur

- Caractère chronique (> 6 mois)
- Mais révélation brutale fréquente (hospitalisation, changement de lieu de vie, etc..)



ATTENTION / facteur majeur de vulnérabilité à la confusion (association fréquente ++++)

1. Définition
2. Mécanique
3. Clinique
4. Importance
5. Prise en soin
6. Pas la confusion

Messages

- La confusion : un syndrome clinique sous-diagnostiqué
- Une population vulnérable, indice d'une fragilité
- Distinguer les éléments non spécifiques de la confusion et les signes spécifiques d'une étiologie (myoclonies,
- Episodes confusionnels répétés (penser soumission chimique ++++)
- Recherches toxiques
- Ne pas rater les causes curables (causes médicales générales, HSV...)

