



Editorial

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Corresponding author:

Bon-Nyeo Koo, M.D., PhD.

Department of Anesthesiology and Pain
Medicine, Severance Hospital, Yonsei
University College of Medicine, 50, Yonsei-ro,
Seodaemun-gu, Seoul 03722, Korea

Tel: +82-10-9982-4469

Fax: +82-2-312-7185

Email: koobn@yuhs.ac

ORCID: <https://orcid.org/0000-0002-3189-1673>

More to be done for the older patients

Bon-Nyeo Koo

Department of Anesthesiology and Pain Medicine, Severance Hospital, Yonsei University
College of Medicine, Seoul, Korea

Cognitive recovery after anesthesia and surgery is a concern for older adults, their families, and caregivers.

In the recent years, an increasing number of older adults have been undergoing anesthesia and surgery. In the western countries, approximately 37% of all surgical procedures were performed on patients more than 65 years of age in 2010, accounting for more than 19 million patients in the USA [1].

In this current issue of the *Korean Journal of Anesthesiology*, Choi et al. [2] reported that anesthetic methods were not associated with the incidence of postoperative delirium through a retrospective analysis of the Korean National Health Insurance claims database including 24,379 cases of total hip replacement arthroplasty. In their report, the incidences of 1.43% and 0.86% in the general and regional anesthesia groups, respectively, were substantially lower than those reported in other studies [3–5]. This discrepancy may be a result of the differences in methods of diagnosing delirium. Choi et al. identified postoperative delirium as the use of postoperative medication for delirium, such as haloperidol, chlorpromazine, olanzapine, and risperidone, as it was not possible to diagnose delirium using the Mini-Mental State Examination or Confusion Assessment Method. Therefore, the incidence of mild or hypoactive delirium may have been overlooked and, consequently, the incidence of postoperative delirium underestimated.

An early diagnosis of postoperative delirium (POD) is critical for a focused and effective treatment [6–11]. The latest clinical guidelines by European Society of Anaesthesiology recommend that patients should not leave the recovery room without being screened for POD [12]. If POD is detected, patients should not be discharged from the recovery room to the ward without having started an etiology- and symptom-based treatment [13]. This is for cases of delirium with a longer duration, and with delayed treatment, cognitive decline may be expected [14]. At the postoperative ward, POD should be monitored at least once per shift because of the fluctuating course of POD [12,15].

In this study by Choi et al. [2], diagnoses of hyperactive delirium were disproportionately represented in comparison with the hypoactive type. Hypoactive delirium is more common than hyperactive delirium [16–18], however, recent retrospective studies found notably lower incidence of hypoactive delirium because of the possible lack of routine screening for symptoms delirium [2,5,19]. For this reason, hypoactive delirium is detected late in time and has the worst prognosis.

The authors concluded that anesthetic methods are not associated with the incidence of postoperative delirium; therefore, depending on the patient's condition and the anesthesiologist's experience, both anesthetic methods should be considered in total hip replacement arthroplasty. However, many older patients and caregivers suffer from POD and its subsequent adverse events.

More rigorously designed multicenter randomized clinical trials and large-scale observational studies are required to determine which is the most appropriate anesthetic tech-

nique, and whether the current best practice recommendations, such as the preoperative cognitive function assessment and routine screening of POD, reduce the incidence of all forms of POD.

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