Delirium and catatonia: Age matters

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OBJECTIVES SPECIFIC AIMS: Background: Delirium is a well described form of acute brain dysfunction characterized by decreased or increased mental alertness in the setting of medical illness and/or abnormal movements, staring, rigidity, and mutism. Delirium and catatonia can co-occur in the setting of medical illness, but no studies have explored this relationship by age. Our objective was to assess whether advancing age and the presence of catatonia are associated with delirium. METHODS/STUDY POPULATION: Methods: We prospectively enrolled critically ill patients at a single institution who were on a ventilator or in shock and evaluated them daily for delirium using the Confusion Assessment for the ICU and for catatonia using the Bush Francis Catatonia Rating Scale. Measures of association (OR) were assessed with a simple logistic regression model with catatonia as the independent variable and delirium as the dependent variable. Effect measure modification by age was assessed using a Likelihood ratio test. RESULTS/ANTICIPATED RESULTS: Results: We enrolled 136 medical and surgical critically ill patients with 452 matched (concomitant) delirium and catatonia assessments. Median age was 64 years (IQR: 62–68). In our cohort of 136 patients, 58 patients (43%) had delirium only, 4 (3%) had catatonia only, 42 (31%) had both delirium and catatonia, and 32 (24%) had neither. Age was significantly associated with prevalent delirium (i.e., increasing age associated with decreased risk for delirium) (p = 0.04) after adjusting for catatonia severity. Catatonia was significantly associated with prevalent delirium (p < 0.001) adjusting for age. Peak delirium risk was for patients aged 55 years with 3 or more catatonia signs, who had 5.4 times the odds of delirium (95% CI: 16.60–176.75) than those with no catatonic signs. Patients 70 years and older with 3 or more catatonia features had half this risk. DISCUSSION/SIGNIFICANCE OF IMPACT: Conclusions: Catatonia is significantly associated with prevalent delirium even after controlling for age. These data support an inverted U-shape risk of delirium after adjusting for catatonia. This relationship and its clinical ramifications need to be examined in a larger sample, including patients with dementia. Additionally, we need to assess which acute brain syndrome (delirium or catatonia) develops first.

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Development of a statin risk communication tool for use in cancer survivors: A pilot

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OBJECTIVES SPECIFIC AIMS: There are currently over a million survivors of childhood, adolescent, and young adult cancer in the United States, many of whom were treated with radiation therapy. Chest radiation with fields including the coronary arteries is a risk factor for cardiovascular disease. Of note, survivors are often unaware of this increased cardiovascular disease risk or, if they are aware, do not know how to mitigate the risk. Visual aids and communicating risk in terms of absolute risk reductions are shown to improve patients’ understanding. The Institute of Medicine recommends use of decision aids to optimize patient discussions of benefits and harms of therapies. Our goal is to develop and pilot test a statin therapy risk communication tool for use in high-risk cancer survivors to improve shared decision making and patient knowledge of coronary artery disease risk. METHODS/STUDY POPULATION: Participants were recruited from the adult long-term follow-up clinic at Sloan Kettering Cancer Center into 2 arms, usual care Versus