APOS CLINICAL REFERENCE HANDBOOKS

Psycho-Oncology

A Quick Reference on the Psychosocial Dimensions of Cancer Symptom Management

SECOND EDITION

EDITED BY
JIMMIE C. HOLLAND, MITCH GOLANT,
DONNA B. GREENBERG, MARY K. HUGHES,
JON A. LEVENSON, MATTHEW J. LOSCALZO,
WILLIAM F. PIRL

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Preface

The first edition of this handbook was published in 2006 by the American Psychosocial Oncology Society (APOS). As the first pocket guide, it served oncology teams well to help them quickly identify and manage the common psychological problems and psychiatric disorders in patients with cancer. The handbook utilized the National Comprehensive Cancer Network (NCCN) distress management guidelines, familiar to oncologists, as its format. At that time, psychological care of patients was not considered part of routine care. It was largely seen as an add-on that could be present or, unfortunately, absent. Two major changes occurred in the oncology policy arena to make that concept obsolete. The Institute of Medicine, after a year-long study, proposed in a 2008 report, that "quality cancer care must integrate the psychosocial domain into routine care." The report noted that there was sufficient evidence base for the psychological and pharmacological interventions and that it was critical that distressed patients be identified and have access to these interventions to truly care for the whole patient. This was followed, in 2012, by the American College of Surgeons Commission on Cancer, putting forward a new accreditation standard that requires that a cancer center have an on-site program to assure that distressed patients are recognized and triaged to a proper treatment resource for psychological care. These two policy statements have given new impetus to the mission to assist oncology staff in identifying distressed patients and family members in routine practice. APOS, Oncology Nursing Society (ONS), and the American Oncology Social Work (AOSW) have provided guidance through a joint white paper supporting these changes and outlining the basic components of an onsite psychosocial program as needed for accreditation.

However, there are not as yet enough mental health professionals on oncology teams to provide the curbside consults that are at the heart of cancer care in places that have mental professionals available. Catching someone in the hallway is still the most common mode of consultation: "Remind me—how I should treat this woman with acute anxiety? What is the best drug and dose?" This updated handbook seeks to provide that information in bulleted and table forms, assuring quick access to scales that are helpful in diagnosis; drugs and their dosages; and treatment recommendations for anxiety, depression, delirium, fatigue and pain. Far more evidence-based interventions are available now for distressed patients, and overall, there are an increasing number of programs in which the psychosocial domain is an integral part of cancer care with a program of screening for distress in all patients. This is an example of effective momentum toward the goal of patient-centered care. Humanism has clearly increased in medical care as

we have taken more into account the ethics of care and research; the desire of patients to choose complementary therapies; and the attention to interventions that address pain, fatigue, and physical symptoms. The handbook is published this time, in 2014, by Oxford University Press which will give it greater visibility with oncologists and their teams. The authors and I share the expectation and pleasure that the information in the handbook will contribute to reducing the distress of patients going through the journey of cancer, and will assist oncologists in more easily treating the whole patient with cancer.

Jimmie C. Holland, MD
Wayne E. Chapman Chair in Psychiatric Oncology
Attending Psychiatrist
Department of Psychiatry & Behavioral Sciences
Memorial Sloan-Kettering Cancer Center
New York, NY

Contributors

Walter F. Baile, MD
Professor of Psychiatry and Behavioral Science
Division of OVP
Cancer Prevention and Population Sciences
The University of Texas MD Anderson Cancer Center
Houston, Texas

Ilana M. Braun, MD
Assistant Professor of Psychiatry
Harvard Medical School
Chief of Adult Psychosocial Oncology
Dana-Farber Cancer Institute
Boston, Massachusetts

Jeremy W. Couper, MBBS, MMed, MD, FRANZCP
Head, Department of Psychiatry
Co-Director Psycho-oncology Research Unit
Peter MacCallum Cancer Centre
East Melbourne, Australia

Carlos G. Fernandez-Robles, MD
Instructor in Psychiatry
Massachusetts General Hospital
Boston, Massachusetts

Mitch Golant, PhD
Senior VP Research & Training
Cancer Support Community
Washington, District of Columbia

Donna B. Greenberg, MD
Associate Professor of Psychiatry
Massachusetts General Hospital
Boston, Massachusetts

Joseph A. Greer, PhD
Assistant Professor of Psychology
Massachusetts General Hospital
Boston, Massachusetts

Rev. George F. Handzo, BCC, CSSBB
Director of Health Services Research and Quality
Healthcare Chaplaincy
New York, New York

Jimmie C. Holland, MD
Wayne E. Chapman Chair in Psychiatric Oncology
Department of Psychiatry & Behavioral Sciences
Memorial Sloan-Kettering Cancer Center
New York, New York

Mary K. Hughes, MS, RN, CNS, CT
Clinical Nurse Specialist
Department of Psychiatry
The University of Texas MD Anderson Cancer Center
Houston, Texas

Kenneth L. Kirsh, PhD
Clinical Research Educator and Research Scientist
Millennium Research Institute
San Diego, California

Mary Jane Massie, MD
Department of Psychiatry & Behavioral Sciences
Memorial Sloan-Kettering Cancer Center
New York, New York

David W. Kissane, MD, MPM, FRANZCP, FAChPM
Head of Psychiatry
Monash University
Clayton, Australia

Jon A. Levenson, MD
Associate Clinical Professor of Psychiatry
Columbia University of College of Physicians and Surgeons
New York Presbyterian Hospital
Attending Psychiatrist
Herbert Irving Cancer Center
New York, New York

Matthew J. Loscalzo, MSW
Liliane Elkins Professor in Supportive Care Programs
Professor of Population Sciences
Administrative Director
Sheri & Les Biller Patient and Family Resource Center
Executive Director
Department of Supportive Care Medicine City of Hope
Duarte, California

Cynthia W. Moore, PhD
Assistant Professor of Psychology
Harvard Medical School Clinical Assistant in Psychology
Massachusetts General Hospital
Boston, Massachusetts

Anna C. Muriel, MD
Assistant Professor of Psychiatry
Harvard Medical School
Chief of Pediatric Psychosocial Oncology
Dana-Farber Cancer Institute
Boston, Massachusetts

Melissa L. Ozga, DO
Department of Psychiatry and Behavioral Sciences
Memorial Sloan-Kettering Cancer Center
New York, New York

Steven D. Passik, PhD
Director of Clinical Addiction Research and Education
Millennium Laboratories
San Diego, California

William F. Pirl, MD, MPH
Associate Professor of Psychiatry
Harvard Medical School
Director
Center for Psychiatric Oncology and Behavioral Sciences
Massachusetts General Hospital
Boston, Massachusetts

Paula K. Rauch, MD
Associate Professor of Psychiatry
Harvard Medical School
Massachusetts General Hospital
Boston, Massachusetts

Xiomara Rocha-Cadman, MD
Instructor in Psychiatry
Bone Marrow Transplant Liason
Memorial Sloan-Kettering Cancer Center
New York, New York

Andrew J. Roth, MD
Psychiatrist
Department of Psychiatry & Behavioral Sciences
Memorial Sloan-Kettering Cancer Center
Professor of Clinical Psychiatry
Weill Cornell Medical College
New York, New York

Isabel Schuermeyer, MD
Department of Psychiatry and Psychology
Cleveland Clinic
Cleveland, Ohio

Jennifer A. Shin, MD
Instructor in Medicine
Massachusetts General Hospital
Boston, Massachusetts

Alan D. Valentine, MD
Professor and Chair of Psychiatry
The University of Texas MD
Anderson Cancer Center
Houston, Texas

Margo W. Walsh, PhD
Department of Clinical
Psychology St. Joseph Medical
Center
Tacoma, Washington

David P. Yuppa, MD
Instructor in Psychiatry
Harvard Medical School
Dana-Farber Cancer Institute
Boston, Massachusetts

Section I

Screening and Interventions

Chapter 1

Screening Instruments

William F. Pirl

Introduction

Screening for psychosocial distress has become a standard required by the American College of Surgeons Commission on Cancer.[1] Many instruments have been developed to assess psychosocial distress and its subtypes in cancer patients. This chapter provides a guide to these instruments. The chapter is organized according to the National Comprehensive Cancer Network (NCCN) distress algorithm, starting with a single-item tool to rapidly assess general psychosocial distress and then focusing on more specific areas of distress as the clinical evaluation proceeds.

General Distress

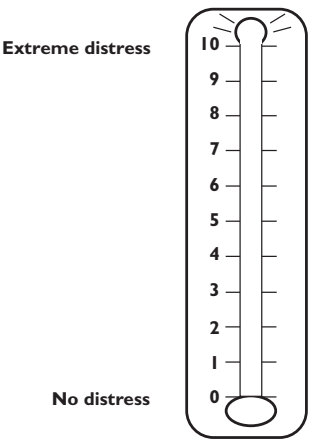
Distress Thermometer

The distress thermometer (Figure 1.1) is a 0–10 scale that asks patients to rate their distress. Scores of 4 or above should have further evaluation. The tool also contains a list of possible problems that patients can check to guide evaluation of the distress and its appropriate treatment. These problems include practical issues, family issues (see Chapter 8), emotional issues (see Chapter 6), spiritual/religious concerns (see Chapter 8), and physical issues (see Chapter 7). If patients check yes to an item under Emotional Problems, you could consider giving them modules of the Patient Health Questionnaire, the Patient Health Questionnaire 9, and Generalized Anxiety Disorder 7. If patients check yes to an item under Spiritual/Religious Concerns, you might consider evaluating this further by taking a spiritual history with the FICA questions under the heading Spirituality. If patients check yes to problems with "memory/concentration" under Physical Problems, consider further assessment with the Mini Mental Status Examination (MMSE).

Some forms of distress may not be readily identified by the distress thermometer such as substance abuse, dementia, and delirium. Based on the patient's history and clinical presentation, other assessments should be done for further evaluation. For substance abuse, consider the Alcohol Use Disorder Identification Test for Clinicians (AUDIT-C) described under the heading Substance Abuse. If there is concern about possible dementia,

SCREENING TOOLS FOR MEASURING DISTRESS

Instructions: First please circle the number (0–10) that best describes how much distress you have been experiencing in the past week including today.



Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

Yes	No	Practical Problems
❑	❑	Child care
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
		Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
		Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities
❑	❑	**Spiritual/religious concerns**

Yes	No	Physical Problems
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urination
❑	❑	Constipatiion
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling Swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Tingling in hands/feet

Other Problems: _____

_____

Figure 1.1 NCCN Distress Management Guideline DIS-A—Distress Thermometer Screening Tools for Measuring Distress. Reproduced with permission from the *NCCN 1.2005 Distress Management, The Complete Library of NCCN Clinical Practice Guidelines in Oncology [CD-Rom]*. Jenkintown, Pennsylvania: ©National Comprehensive Cancer Network, May 2005.

tests under the heading Cognition (on the MMSE) and the Clock Drawing Test should be considered. If there is concern about delirium, the tests under Cognition, including the Memorial Delirium Assessment Scale, should be considered.

Emotional Problems

Patient Health Questionnaire-9

Two modules of the Patient Health Questionnaire[3] (PHQ) (Figure 1.2) can be used to screen for depression and anxiety. Both screeners can be found online at www.phqscreeners.com and are free to use. The PHQ is a self-report instrument, developed to screen for psychiatric disorders in primary care using the *Diagnostic and Statistical Manual, 4th ed. (DSM-IV)* criteria. The full PHQ contains modules that evaluate several specific psychiatric diagnoses including major depressive disorder, panic disorder, generalized anxiety disorder, somatoform disorder, eating disorders, and alcohol abuse.

Patient Health Questionnaire-9 (PHQ-9). The nine items of the PHQ for depression (PHQ-9) can be scored continuously by adding all items for a total score.[4] A cut-off score of 8 has been shown to have the best operating characteristics for identifying cases of depression in individuals with cancer.[4] The PHQ-9 can also be scored categorically to approximate the diagnosis of a major depressive syndrome according to *DSM-IV* criteria. Using this method, probable cases of depression are identified if an individual endorses at least one of the first two items as occurring at least half the days and at least four of the other seven items as occurring at least half the days. The first two items of the PHQ-9 can be used as an even briefer screen and are called the PHQ-2. Answering one of the items as at least half the time is considered a positive screen that should prompt further evaluation. (See Chapter 6, Mood Disorders.)

Generalized Anxiety Disorder—7 Item

The Generalized Anxiety Disorder—7 Item (GAD-7) (Figure 1.3) is a seven-item self-report instrument developed to screen for generalized anxiety disorder in primary care settings, but can be used to screen for most types of anxiety. It is scored by adding all the items for a total score. "Severe" anxiety is considered a score of 15 or higher, "moderate" anxiety is a score of 10–14, and "mild" anxiety is a score of 5–9.

Cognition

Mini Mental Status Examination

The MMSE (Figure 1.4) is a 14-item clinician-administered instrument to assess cognitive impairment, regardless of cause. It contains items on orientation, attention, recall, visual-spatial construction, and language abilities. Scores of 24 or less suggest severe impairment. Further neuropsychological

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(*Use "√" to indicate your answer*)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
FOR OFFICE CODING	0	+ ____	+ ____	+ ____
			= Total Score: ____	

If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
□	□	□	□

Figure 1.2 Patient Health Questionnaire 9 (PHQ-9). Adapted from Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med.* 2001 Sep;16(9):606–613.

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GAD-7				
Over the last 2 weeks, how often have you been bothered by the following problems?				
(*Use "√" to indicate your answer***)**	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
(For office coding: Total Score)	***T*** ____	= ____	+ ____	+ ____)

Figure 1.3 Generalized Anxiety Disorder-7 (GAD-7). Adapted from Spitzer RL, Kroenke K, & Williams JBW. (1999). Validation and utility of a self-report version of PRIME-MD: The PHQ primary care study. *JAMA*, 282:1737–1744.

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assessment is often needed for dementia, particularly assessments that include tests of frontal lobe functioning. The MMSE can be used serially to follow patients at risk for developing cognitive impairment or patients who have had alterations in their cognition, particularly by delirium. (See Chapter 6, Cognitive Disorders.)

Clock Drawing Test

The Clock Drawing Test[7,8,9] (Figure 1.5) is a pen-and-paper test that assesses several cognitive abilities. It is a good adjuvant test of executive functioning when given with the MMSE.[7] Patients are asked to draw a clock on a piece of paper, putting the numbers on the face, and making the hands on the clock designate a specific time, such as 10 minutes before 2. This task tests patients' ability to follow complex commands and to sequence and plan their actions, as well as their visual-spatial ability. The drawn clock can be objectively scored by a validated scoring system. There are two scoring systems, each of which has reasonable sensitivity and specificity in identifying cognitive dysfunction.[8,9] In the Sunderland et al., method, scores of 6 or more are considered normal. (See Chapter 6, Cognitive Disorders.)

INSTRUCTIONS FOR ADMINISTRATION OF MINI MENTAL STATUS EXAMINATION

ORIENTATION

1. Ask for the date. Then ask specifically for parts omitted.
   i.e., "Can you also tell me what season it is?" One point for each correct.
2. Ask in turn, "Can you tell me the name of this place?", town, county, etc. One point for each correct.

REGISTRATION

Tell the person you are going to test their memory. Then say the names of three unrelated objects, clearly and slowly, about one second for each. After you have said all three, ask him to repeat them. This first repetition determines his score (0-3) but keep saying them until he can repeat all three, up to six trials. If the subject does not eventually learn all three, recall cannot be meaningfully tested.

ATTENTION AND CALCULATION

Ask the subject to begin with 100 and count backwards by 7. Stop after five subtractions. Score the total number of correct answers.

If the subject cannot or will not perform this task, ask him to spell the word "world" backwards. The score is the number of letters in correct order.
i.e., dlrow = 5 points, dlorw = 3 points.

RECALL

Ask the patient if he can recall the three words you previously asked him to remember. One point for each correctly recalled.

LANGUAGE

Naming: Show the subject a wristwatch and ask her what it is.

Repeat with a pencil. One point for each named correctly.

Repetition: Ask the patient to repeat the sentence after you. Allow only one trial.

3 Stage Command: give the verbal instructions, then present the subject a sheet of paper. One point for each part of the command that is correctly executed.

Reading: Have the subject read the phrase "CLOSE YOUR EYES". The letters should be large and dark enough for the subject to read. Ask him to "Read the sentence and do what it says." Score correctly only if they read the phrase and close their eyes.

Writing: Give the subject a blank piece of paper and ask her write a sentence for you. Do not dictate a sentence, it is to be written by the subject spontaneously. To score correctly, it must contain a subject and verb and be sensible. It should be a complete thought. Correct grammar and punctuation are NOT necessary.

Copying: On a piece of paper, draw intersecting pentagons, each side about one inch and ask him to copy it exactly as it is. To score correctly, all ten angles must be present AND two must intersect. Tremor and rotation are ignored.

Estimate the subject's level of sensorium along a continuum, from alert to coma.

TOTAL SCORE POSSIBLE = 30
23 OR LESS: HIGH LIKELIHOOD OF DEMENTIA
25–30: NORMAL AGING OR BORDERLINE DEMENTIA

Figure 1.4 Mini Mental Status Examination (MMSE). Adapted from Folstein MF, Folstein SE & McHugh PR (1975). "Mini-mental state." A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*, 12, 189–198; Juby A, Tench S & Baker V (2002). The value of clock drawing in identifying executive cognitive dysfunction in people with a normal Mini Mental State Examination score. *Canadian Medical Association Journal*, 167, 859–864.

MINI MENTAL STATUS EXAM

PATEINT'S NAME: _____

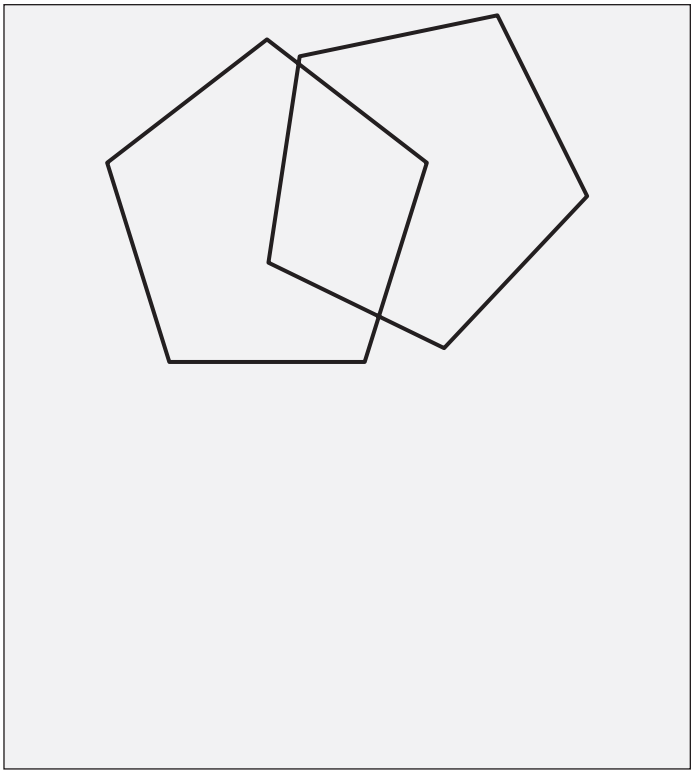
Date: _____ Client's Highest Level of Education: _____

Maximum Score	Score	
		ORIENTATION
5	( )	What is the (year) (season) (date) (day) (month)?
5	( )	where are we: (state) (county) (town) (hospital (floor)?
		REGISTRATION
3	( )	Name 3 objects: One syllable words, 1 second to say each. Then ask the patient all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he learns all 3. Count trials and record. Trials _____
		ATTENTION AND CALCULATION
5	( )	Serial 7's. 1 point for each correct. Stop after 5 answers. Alternatively spell "world" backwards. 100 – 93 – 86 – 79 – 72 – 65 – 58
		RECALL
3	( )	Ask for 3 objects repeated above. Give 1 point for each correct.
		LANGUAGE
9	( )	Name a pencil, and watch (2 points)
	( )	Repeat the following: "No ifs, and or buts." (1 point)
	( )	Follow a 3-stage command: "Take this paper in your right hand, fold it in half, and put it on the floor." (3 points)
	( )	Read and obey the following: "Close your eyes" (1 point)
	( )	Write a sentence. (1 point)
	( )	Copy design. (1 point)

_____
Total Score

Assess level of consciousness _____
along a continuum. (Alert) (Drowsy) (Stupor) (Coma)

Figure 1.4 Continued



Close your eyes.

Figure 1.4 Continued

Memorial Delirium Assessment Scale

The Memorial Delirium Assessment Scale (MDAS) (Box 1.1) is a 10-item clinician-administered assessment that evaluates the areas of cognition most sensitive to impairment with delirium: arousal, level of consciousness, memory, attention, orientation, disturbances in thinking, and psychomotor activity. Scores range from 0 to 30. A score of 13 or above suggests delirium. This scale, used serially, monitors changes in function. (See Chapter 6, Cognitive Disorders.)