

Coming in from the cold....

intensive care induced anxiety state on return of consciousness

Olatosi JO

Consultant Anaesthetist, Department of Anaesthesia, Lagos University Teaching Hospital

Desalu I

Consultant Anaesthetist, Department of Anaesthesia, Lagos University Teaching Hospital

Correspondence to: Dr JO Olatosi, e-mail: tola_olatosi@yahoo.com

■ The Editor:

The emergence from anaesthesia is well known to be a frightening period for patients, as alteration in memory and perception often leads to confusion and resistance. Anaesthetists constantly talk patients through this period, reminding them that they have just had an operation, encouraging them to tolerate whatever airway device may be in place and thus preventing both physical and psychological trauma. In the ICU setting, return of consciousness may not be so well defined, and patients are often left in a vulnerable, confused dream-like state.

We report a case of a middle-aged man who suffered severe psychological trauma on awakening from a five-day coma, after suffering from acute myocardial infarction complicated by renal failure.

Case report

A 58-year old man was admitted to the ICU with a diagnosis of acute myocardial infarction with ventricular tachycardia, complicated by acute renal failure. He was unconscious, acidotic, uraemic and was in cardiogenic shock. He had padded restraints applied to all limbs because he was restless. Treatment included dobutamine, morphine, lidocaine, ceftriaxone and clexane. He also had daily sessions of dialysis for four days.

On the fifth day of admission, he regained consciousness, but was confused as to his whereabouts. He observed that he "was covered with a white bedsheet and could not move any of his limbs as they were all tied down". A male figure dressed in a 'white garment' subsequently came to him and proceeded to 'poke' all over his body and prod his abdomen. This figure then retreated to a corner where he held an intense conversation with a female counterpart occasionally looking in his direction. The pair then returned and attempted to pass a nasogastric tube. He then concluded that he had been kidnapped and held hostage, pending a time when he would become suitable for ritual sacrifice". He became uncooperative and struggled, until the procedure was abandoned. Throughout the night he recalled being observed by at least 4 'ritualists' all dressed in the same white garments who all came to perform various procedures on him which he resisted. He became withdrawn, and finally spent the night in terror whilst pretending to be asleep. The next day, he was approached by another pair of white-clad people who introduced themselves as doctors and explained that he was in a hospital and had been unconscious for 4 days. He was very skeptical about this as he still recognized staff who had attended to him the night previously, in the background. It was not until his daughter arrived in the ICU, that he actually believed he was in hospital and could now recall events preceding his collapse at work. He then communicated his perceptions to the ICU staff and became cheerful and cooperative thereafter. He was finally discharged from the ICU 6 weeks later.

Discussion

Management of patients in the ICU is associated with considerable stress and anxiety which sometimes displaces the psychological welfare of the patient away from the foremost priorities of the intensivist. The physical constraints and social isolation imposed on these patients further coupled with the life-threatening nature of their illness can lead to the development of delusions and hallucinations¹. Posttraumatic stress disorder is a documented complication following ICU psychosis and many patients have required professional psychological support².

The need to verbally communicate with our patients, explaining to them who we are and procedures to be done, highlighting the advantages to the patient cannot be over-emphasized. This encourages cooperation and success with the process. In our patient, it was assumed that in his semi-conscious state he would have been unable to comprehend words and activities, hence the night staff made no attempt to communicate with him. This prevented him having necessary therapy which included nasogastric feeding and drugs, oxygen therapy and physiotherapy and left him in a vulnerable, distressed state.

Hallucinations and dreams as experienced by our patient are a reflection of our society. Nigeria is a developing country in West-Africa. A great proportion of our population still has traditional beliefs and fears, and some still engage in idol-worshipping. Thus one of the most frightening and harrowing situations drummed into our sub-conscious from childhood is to be involved in 'ritual procedures'. News media fuel this nightmare by publishing unconfirmed stories of ritual sacrifices. It was therefore not surprising that this patient faced with a terribly disturbing situation, will link it to his worst possible nightmare and assume he was being prepared for a ritual sacrifice. Nightmares, paranoia and delusions have been reported in patients who have also thought that the medical staff was out to harm or murder them³.

In our institution, ICU is run by anaesthetists as we do not have intensivists. We should therefore import our practices from the theatre, of constantly talking our awakening patients through emergence into the ICU whether we feel they are able to understand or not. Our patient suffered nightmares from this experience and has undergone psychotherapy. He has made good progress which was also helped by strong support from his church.

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References

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