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FOREST PLOTS AND PREDICTION OF POSTOPERATIVE DELIRIUM: MISSING THE FOREST FOR THE TREES?

To the Editor: Van Meenen et al.[1] reviewed prediction models for postoperative delirium focused on participant conditions (age, Mini-Mental State Examination score, alcohol use) with forest plots to visualize variation in odds ratios.

The prevention of delirium through identification and treatment of preexisting concomitant medical problems (e.g., pain, infection) is evidence based but cannot hide that poor organization with limited staff availability or education may be the main avoidable causes of delirium.[2] Are patients always reoriented to time, date, and place? Are unnecessary ward changes avoided? Is time taken to provide reassurance? Are patients rehydrated orally?

Until recently, nicotine withdrawal has been another too-little-recognized cause of agitation. Critically ill smokers on ventilation need supplemental sedatives, neuroleptics, and physical restraints. A robust randomized controlled trial showed that nicotine replacement therapy prevented agitation in smokers with schizophrenia.[3,4] Smoking is common, and all smokers should benefit from prescription of nicotine replacement therapy when hospitalized.

"Prediction is very difficult, especially about the future." Patients may benefit more better implementation of basic care than from development of complex models.

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RESPONSE TO DR. ALAIN BRAILLON

To the Editor: We thank Dr. Alain Braillon[1] for his interest in our work on risk prediction models for postoperative delirium.[2]

We agree with Dr. Braillon that the implementation of basic care, if effective, is important. Comment on his claims on the effectiveness of reorientation to time and place, avoidance of unnecessary ward changes, reassurance and rehydration, and nicotine replacement therapy for smokers is beyond the scope of this letter, but (even simple) prediction models, if valid, may assist healthcare personnel in directing preventive activities to those individuals who are at the highest risk of postoperative delirium and avoiding large investment of time and pertinent resources in individuals predicted to be at (very) low risk. Especially in circumstances in which organization is poor and staff is limited, efficient targeting of high-risk individuals may improve the quality of care. Many clinicians oppose the idea of automation of risk prediction, but it is not always wise to be creative.[3]

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