

Haloperidol (Haldol): reminder of risks when used in elderly patients for the acute treatment of delirium

Elderly patients are at an increased risk of adverse neurological and cardiac effects when being treated with haloperidol for delirium and these adverse effects should be closely monitored.

- Extrapyramidal side effects can cause a **patient's swallow to be impaired** and can lead to **aspiration pneumonia**.
- Haloperidol is associated with **QTc prolongation** and ventricular arrhythmias. Accordingly, use of haloperidol is **contraindicated** in patients with known QTc prolongation, congenital long QTc syndrome and in patients taking other drugs known to prolong the QTc interval. It is recommended a **baseline ECG** is conducted before treatment particularly in patients with cardiovascular risk factors or a history of cardiovascular disease.
- **Blood pressure monitoring** during treatment is also advised and the need for further ECGs during treatment should be assessed on an individual patient basis.
- Due to the risk of **dose-related orthostatic hypotension** from using haloperidol in the elderly, there may be an **increased risk of falls**.



The MHRA conducted a review of UK safety information for haloperidol in the treatment of delirium in frail, elderly patients and made available a [Public Assessment Report](#). No new safety concerns were identified, however the review did identify that the practical use of haloperidol in patients with delirium is variable and is known to be especially associated with adverse effects on the central nervous system. In December 2021 they published a [reminder](#) of the risks of using haloperidol in elderly patients for the acute treatment of delirium.

- **Special caution is required when using haloperidol for the acute treatment of delirium in frail, elderly patients.**
- **Only consider haloperidol for delirium when non-pharmacological interventions are ineffective and no contraindications are present (including Parkinson's disease and dementia with Lewy bodies). Non-pharmacological interventions should be first line.**
- **Before initiating treatment, a baseline ECG and correction of any electrolyte disturbances is recommended; cardiac and electrolyte monitoring should be repeated during treatment.**
- **Prescribe the lowest possible dose for the shortest possible time, ensuring that any dose up-titration is gradual and reviewed frequently (with the aim of stopping haloperidol as soon as possible). NICE recommend haloperidol should be used for usually no longer than 1 week**
- **Elderly patients may have reduced clearance and take longer to eliminate haloperidol and therefore dose adjustment is recommended. The first dose should be treated with caution**
- **Patients with hepatic or renal impairment are also recommended to have doses adjusted**
- **Monitor for and investigate early any extrapyramidal adverse effects, such as acute dystonia, parkinsonism, tardive dyskinesia, akathisia, hypersalivation and dysphagia**
- **Clinical guidance, especially on dosing and monitoring for patients with delirium, should be referred to such as [NICE guidance on delirium](#), [SIGN guidance risk reduction and management of delirium](#), and [British Geriatrics Society guidance on patients presenting with confusion and delirium](#). During the coronavirus (COVID-19) pandemic, haloperidol has also been used for the [treatment of delirium associated with COVID-19](#).**

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If you have any suggestions for future topics to cover in our prescribing tips please contact Nicola.schaffel@nhs.net