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Letter to the Editor

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Inability to answer questions: a pragmatic red flag in altered mental status

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To the Editor,

We read with interest the study by Muhumuza and colleagues on the association between levels of consciousness and 24-h mortality in acutely ill medical patients [1]. The authors should be commended for addressing a pragmatic and clinically important question: how can we rapidly identify patients who require immediate bedside assessment? Their observation that the inability to answer questions using speech was strongly associated with short-term mortality is intuitive and highly relevant to acute medical practice [1].

The simplicity of this binary criterion is appealing, particularly given the well-documented inter-rater inconsistencies of the Alert, Voice, Pain, Unresponsive (AVPU) scale [2, 3]. Nevertheless, several clinical points deserve further consideration before such a rule is integrated into wider emergency care pathways. First, the distinction between an acute deterioration and a patient's pre-existing baseline is crucial. As the authors acknowledge, baseline communication barriers, such as chronic dementia, dysphasia, significant hearing impairment or language barriers, were not specifically recorded [1]. In clinical practice, the prognostic meaning of being 'unable to answer' is likely to differ substantially when it represents a new neurological or systemic deterioration rather than a long-standing functional limitation.

Second, there is a risk that such a simplified trigger might overlook some patients with hypoactive delirium. Our previous multicentre study showed that delirium in elderly emergency department patients with acutely altered mental status is common, heterogeneous and associated with diverse underlying aetiologies [4]. A patient may provide a plausible verbal response while still being inattentive, fluctuating or disorganized. Therefore, although inability to answer questions is a valuable red flag for urgent assessment, it should complement, rather than supersede, structured delirium screening tools such as the 4AT [5].

Finally, the operational challenge of defining a 'plausible response' in the noisy and time-pressured environment of an emergency department should not be underestimated [1, 2]. What appears plausible during routine ward observation may be interpreted differently in an acute intake area, particularly when language, hearing, cognition and cultural context vary between patients.

In summary, we agree that a patient who cannot answer questions should not wait. However, the elegance of a simple rule should not obscure the inherent complexity of altered mental status [1]. Recent geriatric emergency care data also suggest that frailty, baseline function and broader vulnerability may influence subsequent emergency care use and short-term outcomes and should not be reduced to a single bedside marker [6, 7]. Future validation studies should therefore examine the incremental value of this sign when combined with comprehensive neurological, delirium-focused, and geriatric assessment.

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Conflicts of interest

The authors declare that they have no competing interests.

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Data availability

This correspondence did not generate or analyse a new dataset; therefore, data sharing is not applicable.

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