Treatment Easier in Later Elderly Onset Alcoholics

BY DOUG BRUNK
San Diego Bureau

CORONADO, CALIF. — One decisive factor that sets older adults who abuse alcohol apart from their younger counterparts is a generally lower level of tolerance for the substance.

"They may have problems with lower intake due to the increased sensitivity to the alcohol, and therefore have higher blood alcohol levels with less intake," Dr. Louis A. Trevisan said at the annual meeting of the American Academy of Addiction Psychiatry.

According to the National Epidemiologic Survey on Alcohol and Related Conditions, a community survey conducted in

Later elderly onset alcoholics usually begin drinking after a stress-related event.

DR. TREVISAN

2001 and 2002 by the National Institute on Alcohol Abuse and Alcoholism, the prevalence of alcohol use disorder among people aged 65 years and older is 1.35%. Dr. Trevisan, a geriatric and addiction psychiatrist at Yale University, New Haven, Conn., said that elderly alcoholics fall into types: those who start drinking well before they reach age 50 (earlier elderly onset) and those who start drinking after age 50 (later elderly onset).

Earlier elderly onset alcoholics "make up the large majority of older problem drinkers," he said. "They usually have chronic alcohol-related medical problems, a positive family history, serious psychiatric comorbidities." In addition, he said, older problem drinkers usually are less socially adjusted, may have an intractable course and more legal problems, and usually need more medically focused intensive treatment for their addiction.

Later elderly onset alcoholics usually begin drinking after a stress-related event, such as death of a spouse, family member, or close friend, or the loss of a job or a home. "They're usually more emotionally stable, usually have a milder clinical picture, and in general they have greater life satisfaction," Dr. Trevisan said.

They also tend to respond better to treatment, compared with earlier elderly onset alcoholics.

Other risk factors associated with the development of addiction in late life include a personal history of alcohol abuse or use in the past, chronic pain, predisposition to depression or anxiety disorders, and loss of social support or retirement.

Dr. Gregory Acampora, a substance abuse fellow at the Yale/VA Alcohol Research Center, advised clinicians to assess the mental status of older patients with suspected alcohol problems because the effects of alcohol only exacerbate underlying cognitive infirmities. This is important, because cognitive impairment is dose related acutely "and can cause persistent cognitive deficits."

Moreover, dementia often is prevalent in this patient population and affects agnosia, aphasia, apraxia, or a disturbance in executive functioning. The 1% prevalence of dementia for people aged 60-69 doubles every 5 years to a prevalence of about 39% for people aged 90-95 (JAMA 2007; 297:2391-404).

Dr. Acampora also recommended assessing the fall risk in the work-up of any older patient with a suspected drinking problem, noting that gait directly affects long-term outcome.

"The slower you walk, the higher your risk of a fall and of a bad outcome," he said.

In addition, research has demonstrated that a history of problem drinking is associated with a significantly greater risk of falls (J. Am. Geriatr. Soc. 2006;54:1649-57).

He went on to note that medication interaction "has to be considered" in the work-up of older adults with a suspected drinking problem, and that two "misadventures" can occur with patients who take several prescription medications.

"One is that they take all of them—and for each drug there is an increased risk of a drug-drug interaction," Dr. Acampora said. "The other is that they don't take the drug. The disease state may worsen, and a clinician may end up trying to adjust against his belief that a patient is taking the medication" when in fact he or she is not. ■