

Substance Abuse in the Elderly a Growing Issue

BY RENÉE MATTHEWS

BETHESDA, MD. — Current trends in the increase in the number of Americans aged 65 years and older could have significant implications for managing substance abuse in this population.

By 2030, 20% of the population in the United States will be older than 65 years (currently, 13%), and in 2 years' time, the first wave of Baby Boomers will be eligible for Social Security. Both trends will place pressure on retirement and health care systems in general, and on substance abuse prevention and treatment in particular, Frederic C. Blow, Ph.D., said at the annual meeting of the Association for Medical Education and Research in Substance Abuse. The conference was jointly sponsored by Brown Medical School.

"The number of adults with substance abuse disorders is projected to double from [an annual average of] 2.8 million in 2002-2006 to 5.7 million in 2020," he said. In addition, elderly adults who abuse alcohol or drugs are more likely to have mental health comorbidities, especially depression, cognitive loss, or anxiety or sleep disorders, as well as other comorbidities such as heart disease, diabetes, or conditions that require treatment for pain, all of which add another level of complexity in managing substance abuse in this population.

The most common addictions among older adults are to nicotine, alcohol, psychoactive prescription drugs, and other illegal drugs, such as marijuana, cocaine, and narcotics. Estimates suggest that about 19% of older Americans might be affected by combined alcohol and

medication abuse, which is more prevalent among men and those aged 50-64 years.

Aging-related changes make older adults more vulnerable to the adverse effects of alcohol, so even moderate amounts of alcohol can be riskier for elderly drinkers, said Dr. Blow, of the University of Michigan, Ann Arbor.

"They are three times more likely to develop a mental disorder with a lifetime diagnosis of alcohol abuse, with common dual diagnoses, including depression [20%-30%], cognitive loss [10%-40%], and anxiety disorders [10%-20%]," said Dr. Blow, who also noted an association between alcohol abuse and suicide. Moreover, "patients with a history of problem alcohol use ... exhibit more behavioral disturbances, including agitation, irritability, and disinhibition," which increases caregiver distress and therefore caregiver burden.

When it comes to screening for alcohol abuse problems, one should ask direct questions, though in doing so, it is preferable to frame the question so that it is linked to a medical condition and avoid using stigmatizing terms such as alcoholic, Dr. Blow advised. Patients also should be warned that some conditions can be caused or worsened by alcohol use. For example, one or more drinks a day could aggravate or cause gastritis, ulcers, and liver or pancreas conditions; two or more daily might affect depression, gout, insomnia, memory problems; and three or more a day could affect hypertension, stroke, diabetes, gastrointestinal diseases, and some cancers.

"Every person over 60 should be screened for alcohol and prescription drug abuse as part of the regular

physical examination—and screen or rescreen if certain physical symptoms are present or if the older person is undergoing major life transitions," he added.

Among the tools that can be used for screening and assessing alcohol use in the elderly are the Alcohol-Related Problems Survey and its shorter version, the shARPS; the Computerized Alcohol-Related Problems Survey, which combines screening assessment with health education; AUDIT-C, which screens for alcohol consumption; and two that are "elder-specific"—the Michigan Alcoholism Screening Test—Geriatric Version and the Short Michigan Alcohol Screening Instrument—Geriatric Version.

In regard to drinking limits, older men should have no more than one drink a day on average, and older women should have less than one drink a day, Dr. Blow said. The cut-off for binge drinking in the elderly is four or more drinks in a drinking day for men, and three or more in a drinking day for women.

Brief interventions focusing on physician lifestyle guidance or in-home motivational enhancement have both been found to reduce alcohol use in at-risk older adults and alcohol-related harm, and as a result, health care use.

However, when it comes to treatment, age-appropriate treatment models are essential. "The current bias toward institution-based services conflicts with expressed preferences and needs of older persons," said Dr. Blow, noting that home and community-based settings are in fact preferable for older adults, as are mixed-age treatment settings when individualized psychotherapeutic approaches are included.

Compared with their younger counterparts, older at-risk adults have greater attendance at therapy sessions, better medication adherence, and lower relapse rates, he said.

Dr. Blow said he had no financial disclosures. ■

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Exercise Capacity Independent Predictor in Diabetic Elderly

BY MITCHEL L. ZOLER

ORLANDO — In elderly patients with diabetes and no history of coronary artery or peripheral artery disease, exercise capacity less than 85% of the predicted value independently identified patients at increased risk for death, stroke, or myocardial infarction in a study of more than 600 patients.

"This is the first study in patients with diabetes and without known coronary artery disease" to show that functional capacity predicts outcome, Dr. Wilbert S. Aronow said at the annual scientific sessions of the American Heart Association.

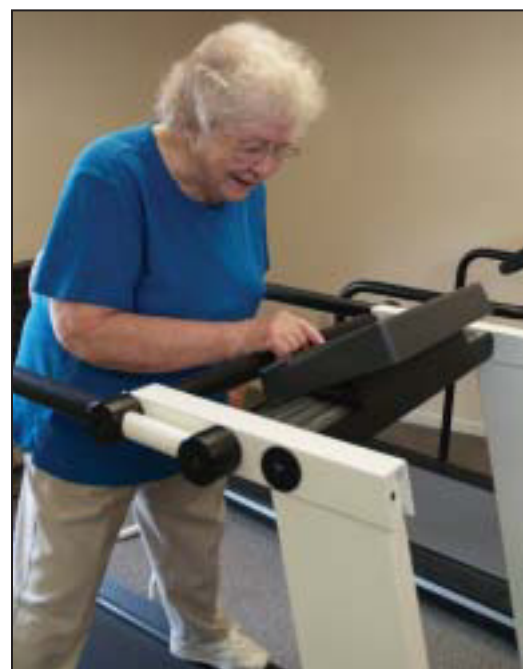
The finding suggests more aggressive use of a treadmill exercise sestamibi stress test (TESST) to screen patients with diabetes, especially as they get older. "Zero in on these patients; they are at greater risk," said Dr. Aronow, a cardiologist at New York Medical College in Valhalla. Older patients with diabetes who show poor exercise capacity on a TESST need aggressive treatment by lipid-lowering drugs and blood pressure control, regardless of the extent of their vascular disease. It's also possible that exercise training could improve outcomes in these patients, although Dr. Aronow admitted that the value of exercise training must be proved in a controlled study.

"Especially in elderly patients with long-duration diabetes, the [manage-

ment] approach should focus on blood pressure and on lowering low-density lipoprotein cholesterol," commented Dr. Prakash C. Deedwania, professor of medicine and chief of cardiology at the University of California, San Francisco, in Fresno.

The study included 609 consecutive patients with diabetes and no history of coronary artery disease, peripheral artery disease, pulmonary disease, or diabetic neuropathy. Their average age was 70 years. All patients underwent a TESST, the duration of which was limited by dyspnea in all cases; none of the patients had chest pain during the exercise test.

Dr. Aronow and his associates calculated the percentage of predicted exercise each person achieved based on their age and sex. A peak exercise level less than 85% of predicted occurred in 301 patients (49%), and a level of 85% or greater occurred in the other 308 (51%). The two subgroups had similar profiles for age, sex, race, smoking prevalence, hypertension, dyslipidemia, body mass index, renal function, duration of diabetes, and use of insulin, aspirin, statins, angiotensin-converting enzyme inhibitors, and angiotensin receptor blockers. In all, 241 of the patients also underwent coronary angiography, including 128 patients from the low exercise-capacity group and 113 from the



Older patients with diabetes who show poor exercise capacity need aggressive treatment.

group with a level of 85% or greater.

Angiography revealed multivessel obstructive coronary disease in 38% of the low exercise-capacity patients and in 18% of the higher exercise-capacity patients, a statistically significant difference.

After an average follow-up of 47 months, low exercise-capacity patients had a mortality rate of 10%, and a combined rate of death, myocardial infar-

tion, or stroke of 21%. In contrast, the higher exercise-capacity patients had a mortality rate of 4% and a combined event rate of 12%, statistically significant differences between the two subgroups.

A multivariate analysis that controlled for 20 baseline variables showed that patients with an exercise capacity of 85% or greater had a significant 48% reduced risk for death, myocardial infarction, or stroke, compared with the other group. Exercise capacity was the only significant predictor of these events in the model.

Patients who stop an exercise test because of dyspnea probably have exercise-induced left ventricular dysfunction, Dr. Deedwania said. In elderly patients with diabetes, coronary disease often does not manifest

as chest pain, but rather as heart failure symptoms, he noted. The important prognostic role of exercise capacity in these patients conforms with results from several other studies showing that "functional capacity is a very powerful predictor of outcome in all types of patients," he added.

Dr. Aronow had no financial disclosures for his study. ■