Alcohol Use and Overuse in Older Adults

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I have no disclosures

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Biography

- Received both my BSN and MSN degrees from Purdue University
- I have been practicing as nurse practitioner for 10 years, the entirety of that time spent in managing geriatric care
- I am married and have 2 little girls, 6 and 8 years old

Older Adult Alcohol Use

Older Adult Alcohol Use

- Nearly 50% of adults over age 65 years consume alcohol.
- Of those, estimates show that 14.5% drink more than the recommended weekly allowance (>7 drinks per week) or binge drink.
- Alcohol is the most common addiction in older adults

Older Adult Alcohol Use

What's the harm in a few drinks?

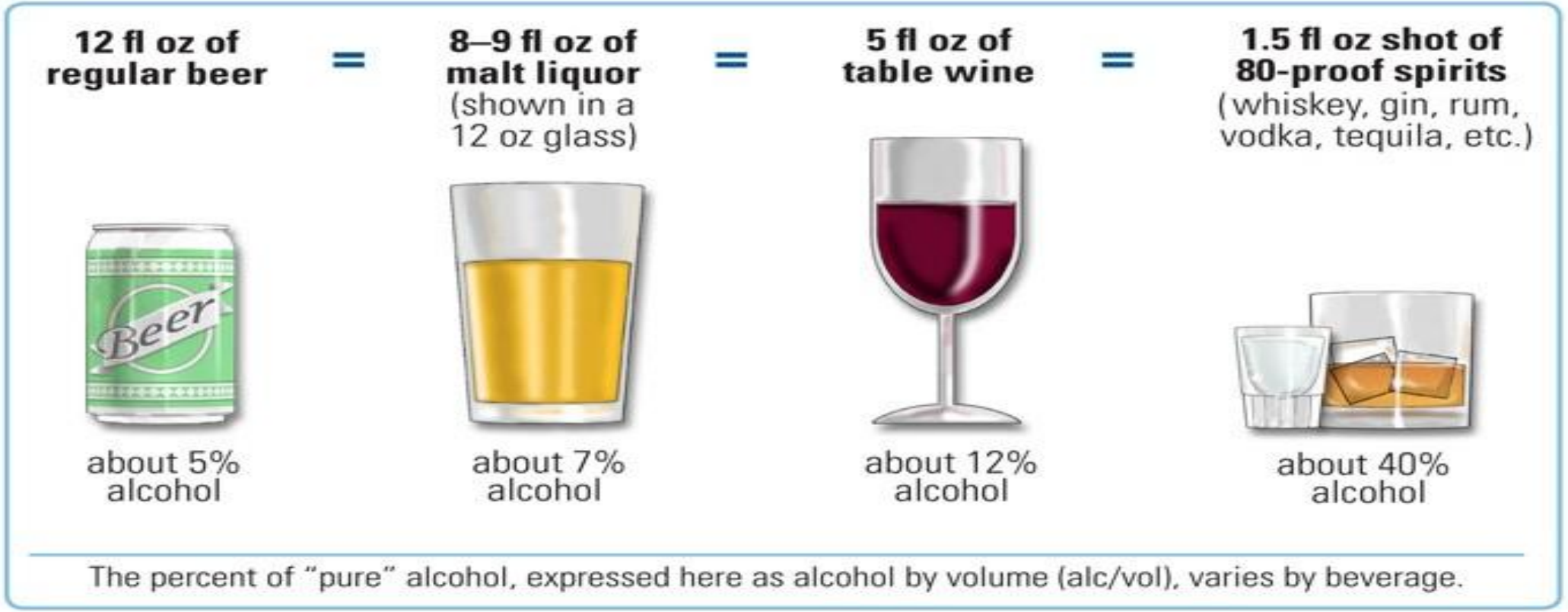
Low/moderate consumption of alcohol can be beneficial for:

- Heart disease
- Potential to prevent neurocognitive disorders
- Social aspects

Recommended Alcohol Use in Older Adults

- On average, no more than 1 drink per day for older men or less than one drink per day for older women
- Binge drinking is considered drinking 4 or more drinks on one occasion for men and more than 3 drinks for women

Whats a standard drink in the US?



National Institute on Alcohol Abuse and Alcoholism

Older Adult Alcohol use

Age-related changes lead to increase vulnerability

- Higher blood alcohol concentration (BAC) from a given amount (they get drunk faster)
- More impairment at a given BAC (they feel the effects more)
- Concern for interactions with chronic illnesses and medications

This means:

- Moderate levels of consumption in older adults is riskier for resulting in negative consequences

However:

- Despite these heightened risks, older adults are less likely to be screened for alcohol than other groups. When screening does occur it usually ignores the combined health and medication factors that put older adults at greater risk.

Older Adult Alcohol Use

- With consideration to current medical problems, a survey classified 53% of older drinkers as having harmful or hazardous patterns of of alcohol use
- Alcohol use in older adults is often associated with increased risk of falling and can negatively impact function, cognition, and general health

Older Adult Alcohol Use

Risk factors for alcohol abuse in older adults include depression, anxiety, bereavement, pain, disability, and a prior history of alcohol overuse

4Ms

- What **M**atters--socialization
- **M**edications--interactions
- **M**entation--negative effects on cognition
- **M**obility--falls, disability, pain

Impact of COVID-19

- Study shows older adults among specific populations to have increased alcohol usage
- Increased risk of alcohol usage due to isolation and loneliness; cut off from support networks
- Alcohol exacerbates risk taking behaviors (not wearing a mask, participating in large gatherings), mental health issues (depression, anxiety), and falls.
- Decreases one's resilience and capacity to handle stress
- Compromises the body's immune system
- WHO recommends to minimize alcohol use during the pandemic

Alcohol Use Disorder

- The DSM-5 replaced the diagnoses of alcohol abuse and alcohol dependence with one diagnosis, alcohol use disorder. It's measured in a continuum from mild to severe.
- **Alcohol dependence** is approximately comparable to alcohol use disorder, **moderate to severe subtype**, while **alcohol abuse** is similar to the **mild subtype.**
- Alcohol use disorder is characterized by a problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by 11 specific psychosocial, behavioral, or physiologic criteria. Mild = 2-3 symptoms, moderate = 4-5 symptoms, and severe = 6 or more symptoms

Screening for Alcohol Use in Older Adults

CAGE Questionnaire

Consists of four questions, easy screen, not sensitive for detecting the whole spectrum of unhealthy use, not geriatric specific

1. Have you ever felt you should **Cut** down on your drinking?
2. Have people **Annoyed** you by criticizing your drinking?
3. Have you ever felt bad or **Guilty** about your drinking?
4. Have you ever taken a drink first thing in the morning (**Eye-opener**) to steady your nerves or get rid of a hangover?

A single affirmative response should be considered a positive test

Comorbidity Alcohol Risk Evaluation Tool (CARET)

- Assesses consumption, comorbidities, and medication use to identify older adults at risk for negative consequences from alcohol
- 10 questions

Michigan Alcoholism Screening Test--geriatric version (MAST-G)

- Primarily detects alcohol use disorders
- 24 yes/no questions

Outpatient Management of Alcohol Withdrawal

Initial Assessment

- Substance use history
  - Specifically last drink, how many drinks per day/week, history of withdrawal seizures or delirium tremens, number of previous withdrawal episodes
- General medical history and comorbidities
- Vital signs
- Physical exam
- Laboratory evaluation
  - Include CBC with diff, blood glucose, electrolytes, calcium, magnesium, phosphorus, anion gap, and renal and hepatic function
- Withdrawal symptoms
  - Evaluated initially and serially over the course of the withdrawal period
  - Can use the 10 question Clinical Institute Withdrawal Assessment from Alcohol--Revised (CIWA-Ar) scale. Helps to categorize the severity of the withdrawal and if outpatient management is appropriate

Timing of alcohol withdrawal syndromes

Syndrome	Clinical findings	Onset after last drink
Minor withdrawal	Tremulousness, mild anxiety, headache, diaphoresis, palpitations, anorexia, gastrointestinal upset; normal mental status	6 to 36 hours
Seizures	Single or brief flurry of generalized tonic-clonic seizures, short postictal period; status epilepticus rare	6 to 48 hours
Alcoholic hallucinosis	Visual, auditory, and/or tactile hallucinations with intact orientation and normal vital signs	12 to 48 hours
Delirium tremens	Delirium, agitation, tachycardia, hypertension, fever, diaphoresis	48 to 96 hours

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Indications for Outpatient Management of Alcohol Withdrawal

- Patient with mild symptoms of alcohol withdrawal (CIWA-Ar score <15)
- Alternatively an asymptomatic patient with history of symptoms with past attempts to reduce drinking
- No history of delirium tremens or alcohol withdrawal seizures
- Must be cognitively intact and motivated
- Able to take oral medications
- Must commit to near daily visits
- No significant medical or psychiatric comorbidities or abnormalities on exam/lab work

Medication Management

- **Lorazepam**--Short acting benzodiazepine, has fewer metabolites that depend on liver function
- **Gabapentin**--A gamma-aminobutyric acid (GABA) analogue that has emerged in recent years as an effective and safe alternative to benzodiazepines in the treatment of mild alcohol withdrawal. Has been shown to be less sedating than benzodiazepines. Anticonvulsants in general believed to counteract the “kindling process” with repeated episodes of alcohol withdrawal causing intensification of alcohol withdrawal symptoms with repeat episodes
- All patients should receive a multivitamin containing thiamine and folate to decrease likelihood of worsening encephalopathy

Lorzepam Dosing

Very mild withdrawal symptoms (CIWA-Ar score <10)

- Day 1 - 2 to 4mg every 6 hours as needed
- Day 2 to 5 - 2mg every 6 hours as needed

Mild withdrawal symptoms (CIWA-Ar score 10 to 15)

- Day 1 - 2 to 4mg every 6 hours
- Day 2 - 2mg every 8 hours
- Day 3 - 2mg every 12 hours
- Day 4 - 2mg at night

Gabapentin Dosing

Very mild to mild withdrawal symptoms (CIWA-Ar score 0 to 15)

- Day 1 - 300mg every 6 hours
- Day 2 - 300mg every 8 hours
- Day 3 - 300mg every 12 hours
- Day 4 - 300mg one dose

Management Continued

- Duration of treatment can range from one or two days to as long as seven days depending on severity of withdrawal symptoms
- Recommended clinicians be in contact with patients daily--could alternate phone and in person visits
- At each visit--vital signs, physical exam, reassessment with the CIWA-Ar
- To minimize opportunities for misuse or diversion a one day supply of medication can be prescribed daily
- Patient needs support person to stay with them and monitor withdrawal symptoms

Management Complications

- Patient discontinuation of treatment or nonadherence to medication scheduling
- Inadequate response to treatment
- Resumption of alcohol use
- Electrolyte abnormalities

Occurrences of one or more of these events prompts transition to higher level of care

Post-withdrawal Management

- Treatment of the withdrawal period does not treat the alcohol use disorder
- Patients are at high risk for relapse
- Will need explicit plans for follow up care--this can involve continued treatment through primary care or a specialized alcohol treatment program
- Ongoing review of the 4Ms

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QUESTION & ANSWER

Ashleigh McAfee, Kacey Carroll, Lynn Collins, Danielle Davis

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10 MIN BREAK

We will resume at 1:50pm

FEEL FREE TO USE THE CHAT FEATURE TO CONNECT WITH OTHER PARTICIPANTS. IF YOU LEAVE THE ZOOM MEETING, BE SURE TO SAVE THE ZOOM LINK (OR MEETING ID) TO LOG BACK ONTO THE CALL

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