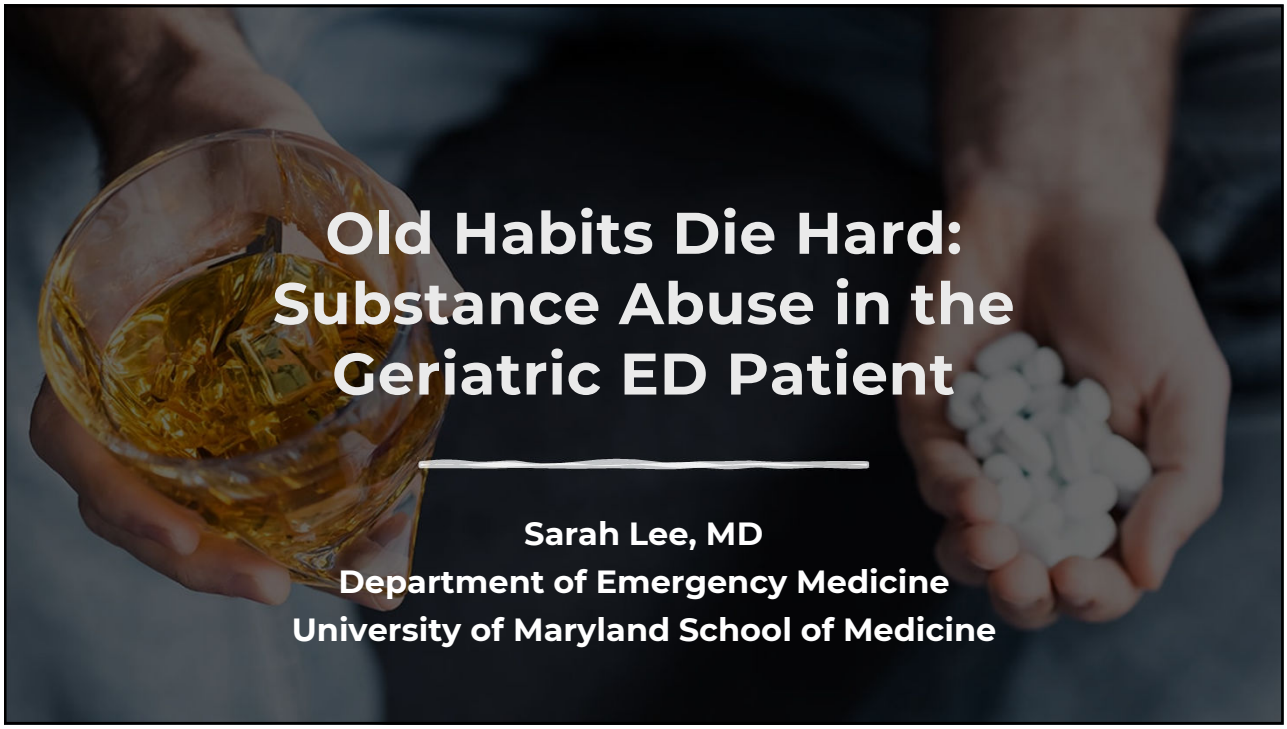

Old Habits Die Hard:
Substance Abuse in the
Geriatric ED Patient
Sarah Lee, MD
Department of Emergency Medicine
University of Maryland School of Medicine

1


No financial disclosures

2

Objectives

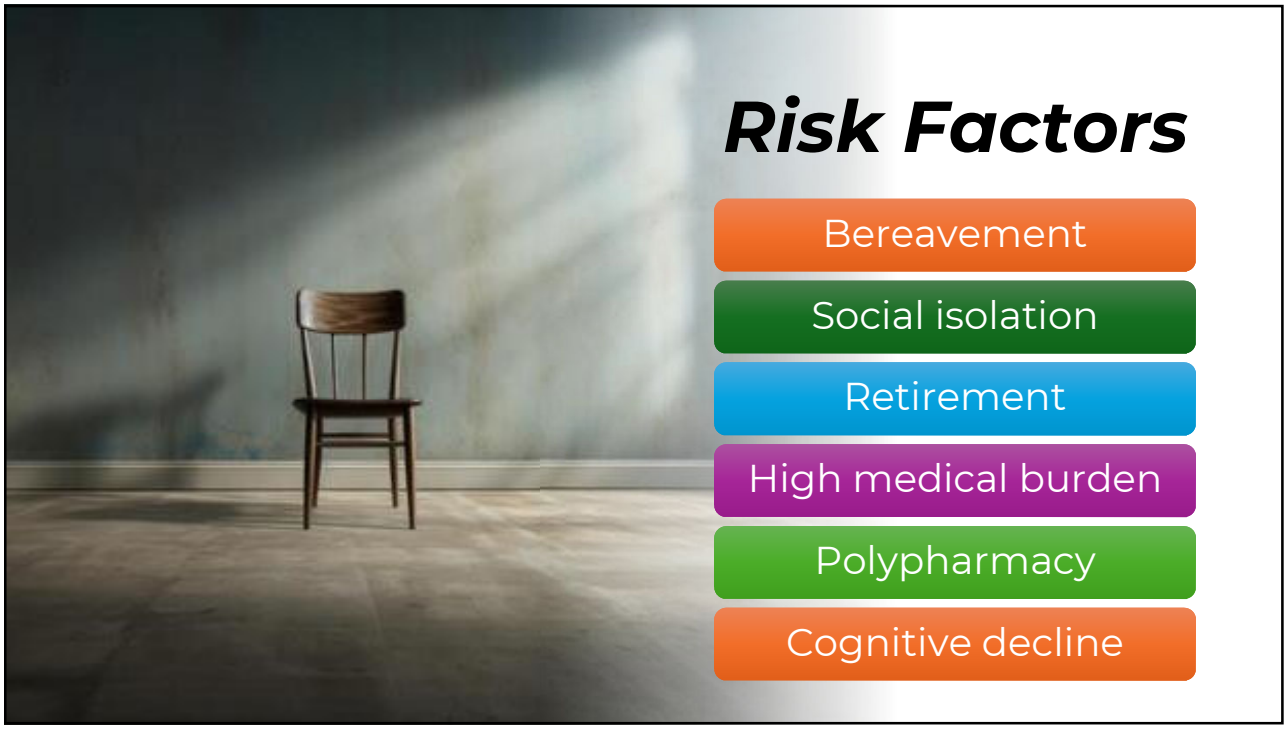
- **Identify atypical presentations of substance use disorders in geriatric patients**
- **Review how to screen for substance use disorders in geriatric patients**
- **Optimize medical management of withdrawal syndrome for geriatric patients**

3

Epidemiology

- Substance use disorders in adults ≥65 are under-recognized
- 1 in 11 adults over 60 had an identified substance use disorder in 2022
- Most common: alcohol and prescription drugs
- Drug overdose deaths for adults >65 have more than tripled between 2000 and 2020

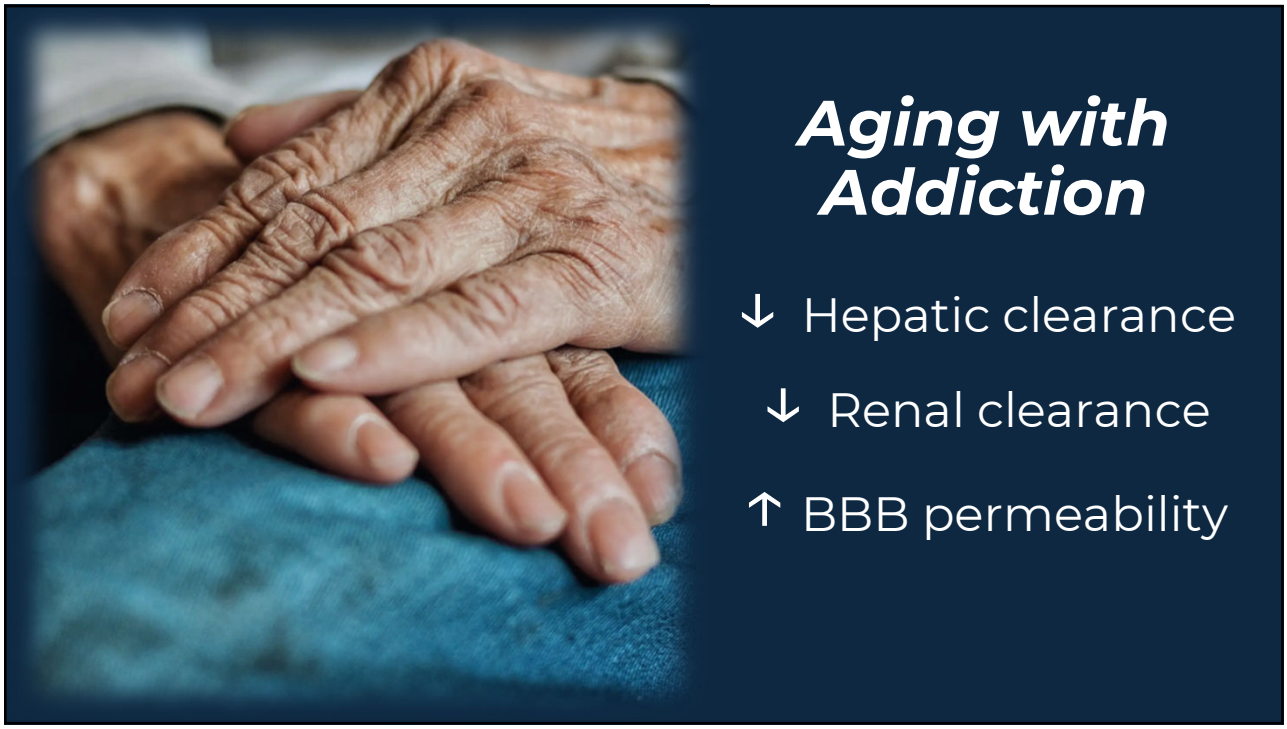
4


Risk Factors
Bereavement
Social isolation
Retirement
High medical burden
Polypharmacy
Cognitive decline

5


Aging with Addiction
↓ Physiologic reserve
↓ Lean body mass
↓ Total body water

6


Aging with Addiction
↓ Hepatic clearance
↓ Renal clearance
↑ BBB permeability

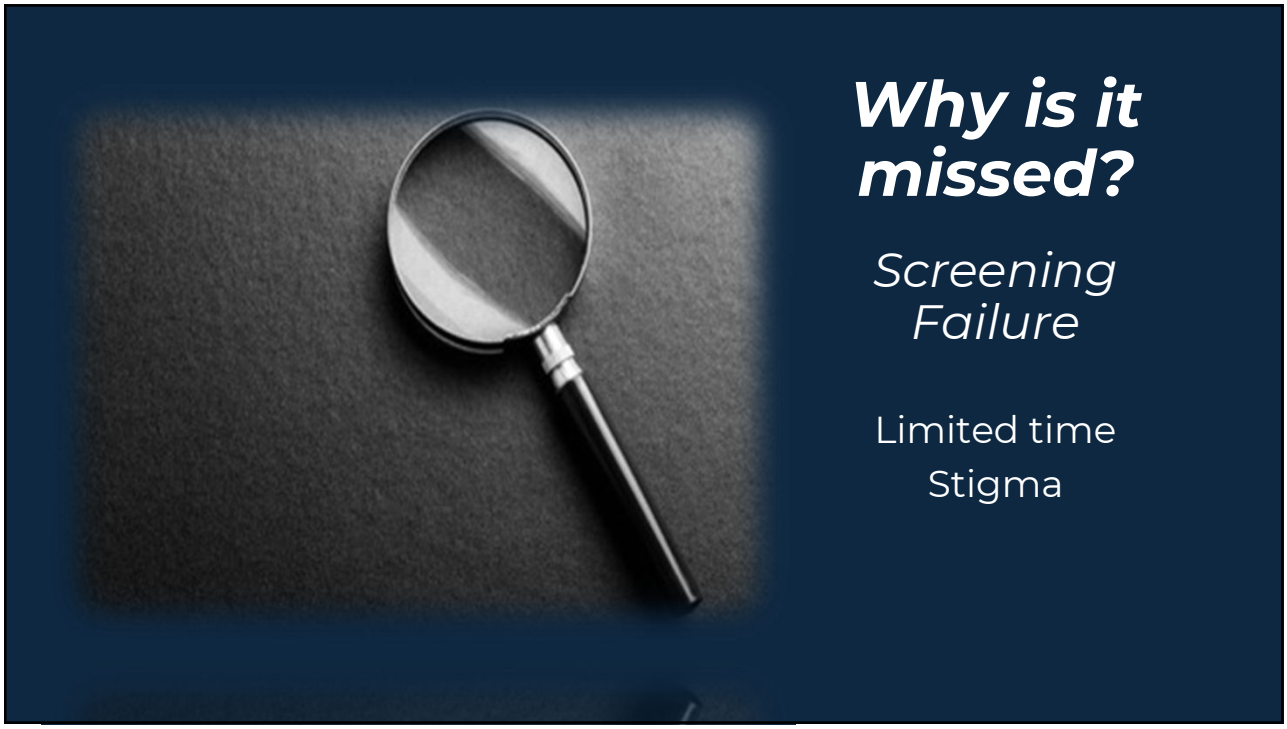
7


Why is it missed?
Atypical presentations
Frequent falls
GI bleed
Failure to Thrive
Delirium
Occult withdrawal

8


Why is it missed?
Age-ism Bias
We don't think to ask

9


Why is it missed?
Screening Failure
Limited time
Stigma

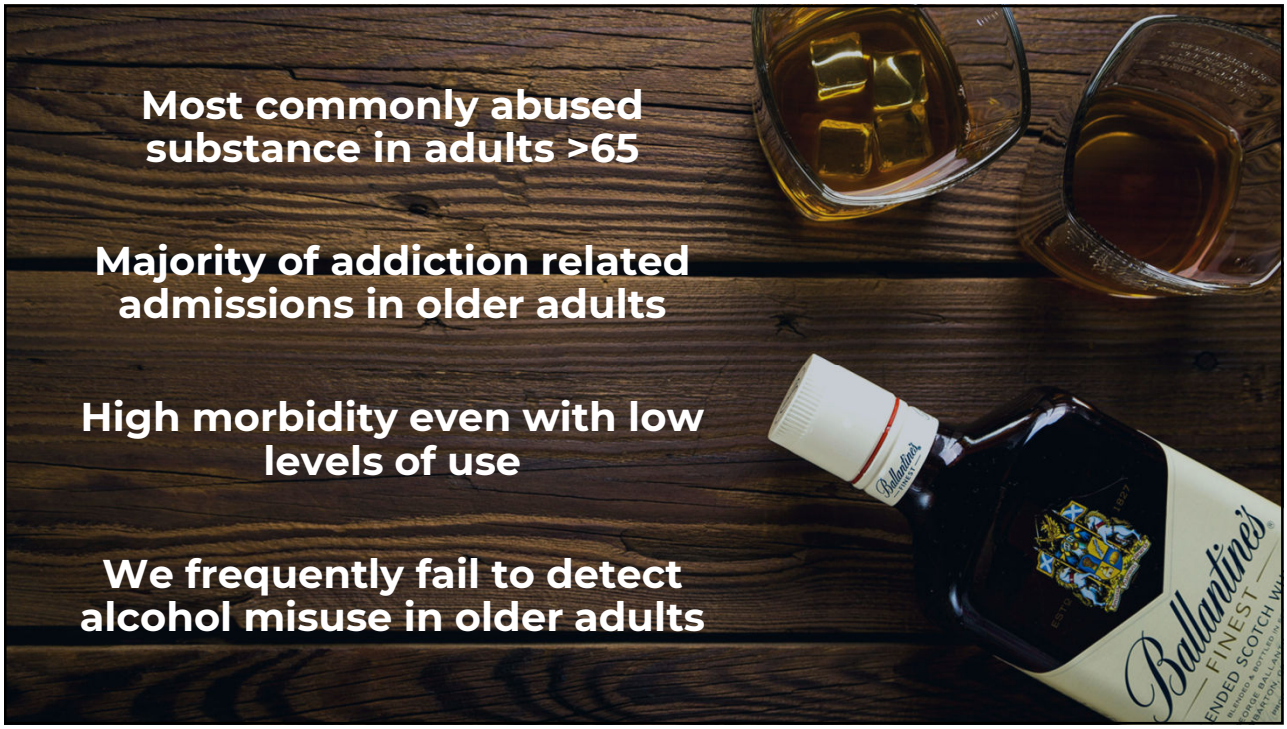
10


COMPONENTS OF THE CAGE QUESTIONNAIRE
C
Have you ever felt the need to Cut down on drinking?
A
Have people Annoyed you by criticizing your drinking?
G
Have you ever felt Guilty about drinking?
E
Have you ever had a drink first thing in the morning (an Eye-opener) to steady nerves or get rid of a hangover?
NESTLED
The Alcohol Use Disorders Identification Test: Interview Version
Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.
1. How often do you have a drink containing alcohol?
(0) Never [Skip to Qs 9-10]
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more
3. How often do you have six or more drinks on one occasion?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily
Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0
4. How often during the last year have you found that you were not able to stop drinking once you had started?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily
5. How often during the last year have you failed to do what was normally expected from you because of drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily
9. Have you or someone else been injured as a result of your drinking?
(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year
10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?
(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year
Record total of specific items here
If total is greater than recommended cut-off, consult User's Manual.
Why is it missed?
Screening Failure
CAGE
AUDIT

11


Ballantine's
FINEST

12


Most commonly abused substance in adults >65
Majority of addiction related admissions in older adults
High morbidity even with low levels of use
We frequently fail to detect alcohol misuse in older adults
Ballantine's
FINEST

13


Screening
~~CAGE~~
~~AUDIT~~

14

G-MAST

Short Michigan Alcoholism Test Geriatric Version (SMAST-G)

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Source: University of Michigan Alcohol Researtch Center. Reprinted with permission.

		Yes (1)	No (0)
1	When talking with others, do you ever underestimate how much do you drink?		
2	After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?		
3	Does having a few drinks help decrease your shakiness or tremors		
4	Does alcohol sometimes make it hard for you to remember parts of the day or night?		
5	Do you usually take a drink to relax or calm your nerves?		
6	Do you drink to take your mind off problems?		
7	Have you ever increased your drinking after experiencing a loss in your life?		
8	Has a doctor or nurse ever said they were worried or concerned about your drinking?		
9	Have you ever made rules to manage your drinking?		
10	When you feel lonely, does having a drink help?		

Total SMAST G Score (0-10) _____

SCORING 2 OR MORE **"YES"** RESPONSES IS INDICATIVE OF AN ALCOHOL PROBLEM.

15

NIAAA Single Question

How many times in the past year have you had >4 drinks in one day?

16

Complications of AUD

Trauma: falls / MVCs
Delirium
Pancreatitis
GI Bleeding
AKA

17

Complications of AUD

Liver disease
HTN, Afib, HF
Dementia
Peripheral Neuropathy
Wernicke-Korsakoff
PUD, Gastritis, Esophagitis
Depression, Insomnia

18


Alcohol Withdrawal

19


24-72+ Hours
Delirium Tremens
12 – 24 Hours
Hallucinosis
Seizures
6-12 Hours
Tremors, Vomiting,
Tachycardia

20

Alcohol Withdrawal: Geriatric Considerations

Misleading Vitals

Lower seizure threshold

High mortality and complication rate

21

Alcohol Withdrawal: Geriatric Considerations

Aspiration Risk

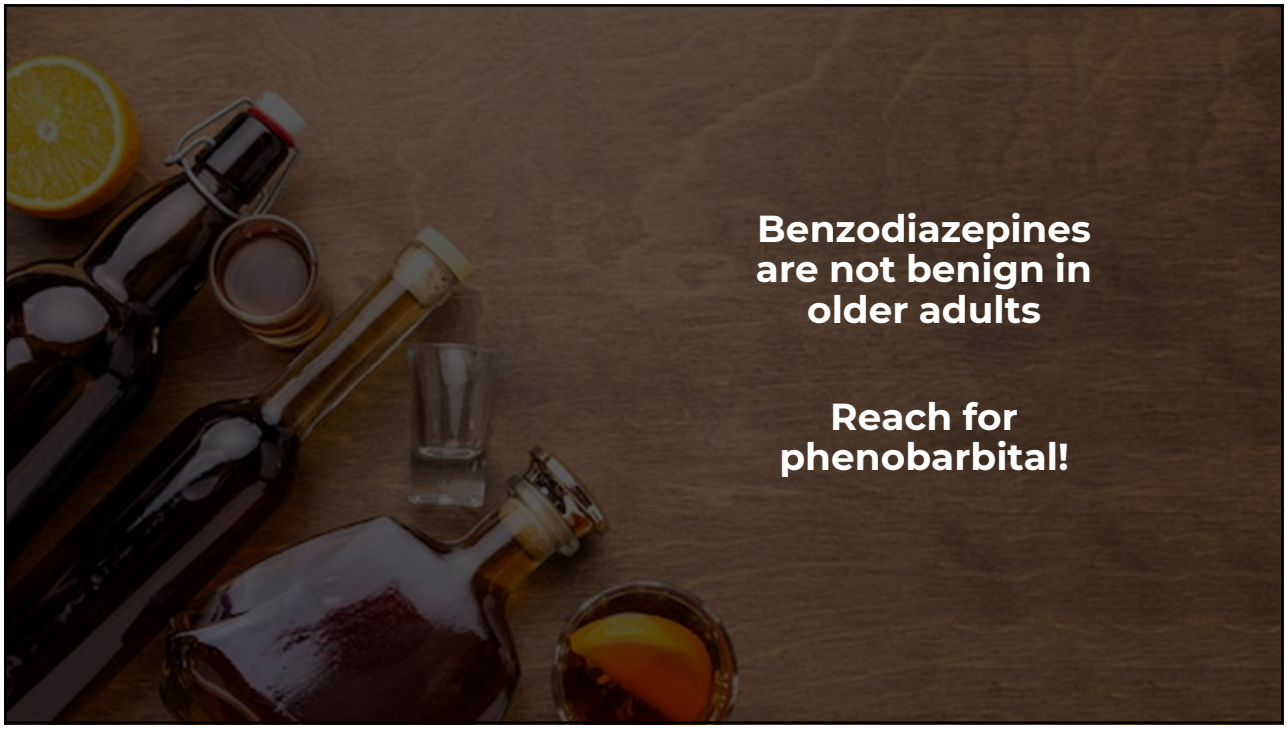
Don't Miss Delirium

Slower Recovery

22


Alcohol
Withdrawal
Management

23


Benzodiazepines
are not benign in
older adults
Reach for
phenobarbital!

24

PHENOBARBITAL

Barbiturate

Activates GABA

Inhibits Glutamate

25

PHENOBARBITAL

Route: PO, IM, IV

Onset: 5-10 minutes IV

Half Life: 80 - 120 hours

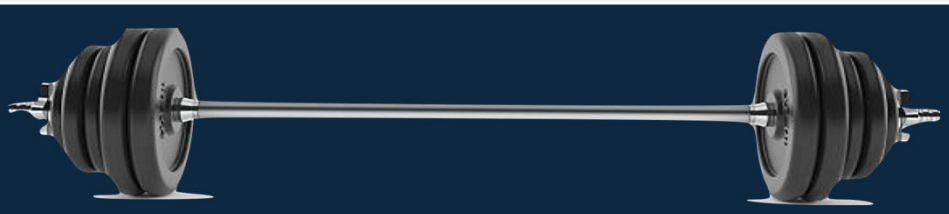
26

Dosing

Standard: 10 mg/kg IV (Ideal Body Weight)

Consider slower titration: 130-260mg IV repeat every 15-30min until effect

High Risk Patient: consider 6 mg/kg IV



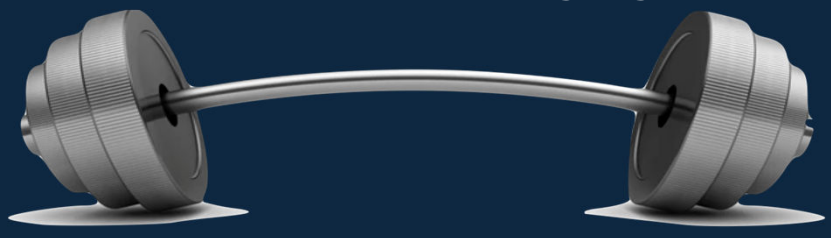
27

PHENOBARBITAL: PITFALLS

Avoid in liver disease

Apnea

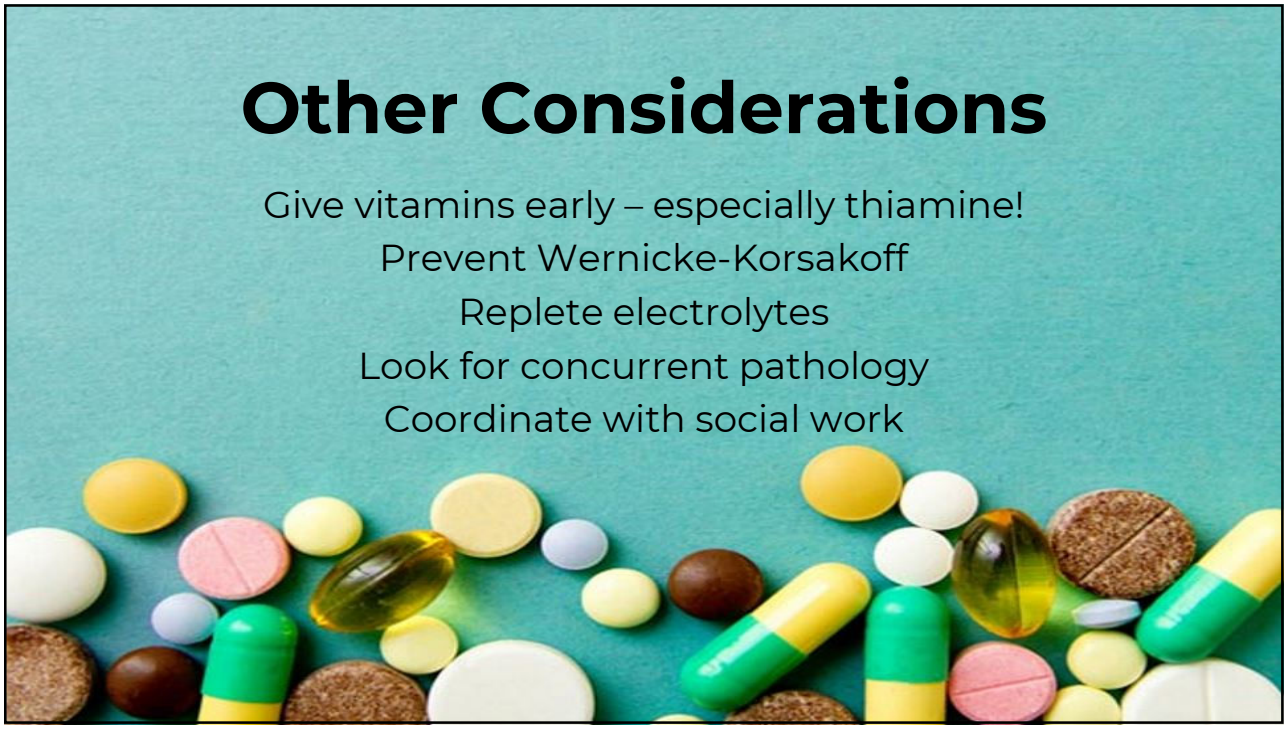
Limit: 20-30mg/kg



28


Alcohol Withdrawal Management
Benzodiazepines are not benign in older adults
Reach for phenobarbital!

29


Other Considerations
Give vitamins early – especially thiamine!
Prevent Wernicke-Korsakoff
Replete electrolytes
Look for concurrent pathology
Coordinate with social work

30

Opioid Use Disorder

ED visits by older adults with opioid misuse increased by ~220% from 2006 to 2014

31

Opioid Use Disorder

Overdose deaths in adults >65 have tripled in the past 20 years

32


Public health challenge
Prescription drug misuse
Often begins with
legitimate pain treatment

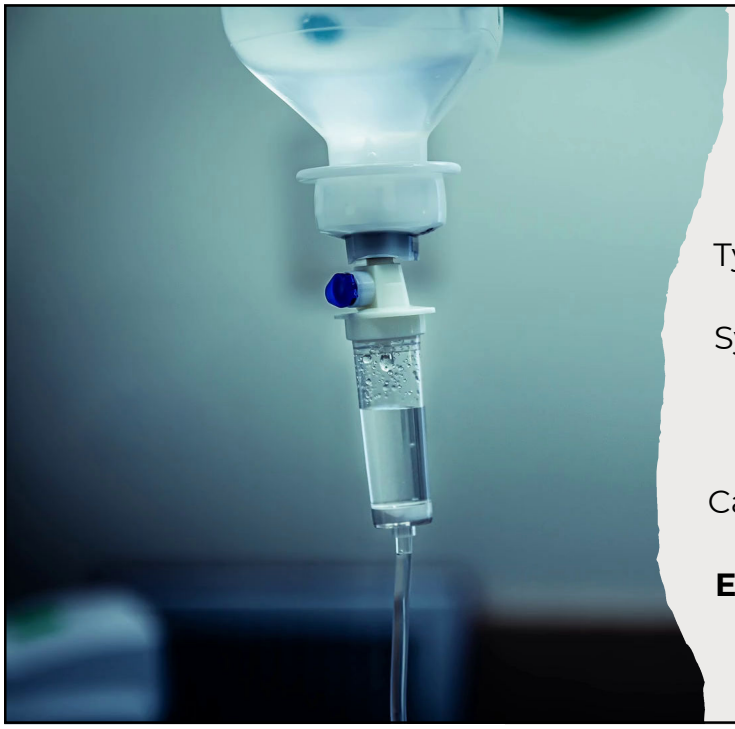
33


Risk
Factors
Chronic pain
Multiple prescribers
Co-prescribed sedatives
Renal impairment
Social isolation

34

1 year mortality rate for patients after ED visit for nonfatal opioid overdose is 5%

35



Opioid Withdrawal

Typically not life-threatening but high morbidity

Symptoms delayed or atypical in older adults

Frequently mistaken for pain, anxiety, infection

Can precipitate falls, dehydration, delirium

ED is critical intervention point

36

Buprenorphine

Partial μ-opioid agonist with high receptor affinity

Reduces withdrawal, cravings, and overdose risk

Ceiling effect = lower risk of respiratory depression

Can be initiated safely in ED

37

Buprenorphine + Naloxone

Buprenorphine = active medication

Naloxone: inactive when taken sublingually

Combination reduces misuse

Can be initiated safely in ED

38

Buprenorphine + Naloxone

Buprenorphine = active medication

Naloxone: inactive when taken sublingually

Combination reduces misuse

Can be initiated safely in ED

39

Full μ-opioid agonist

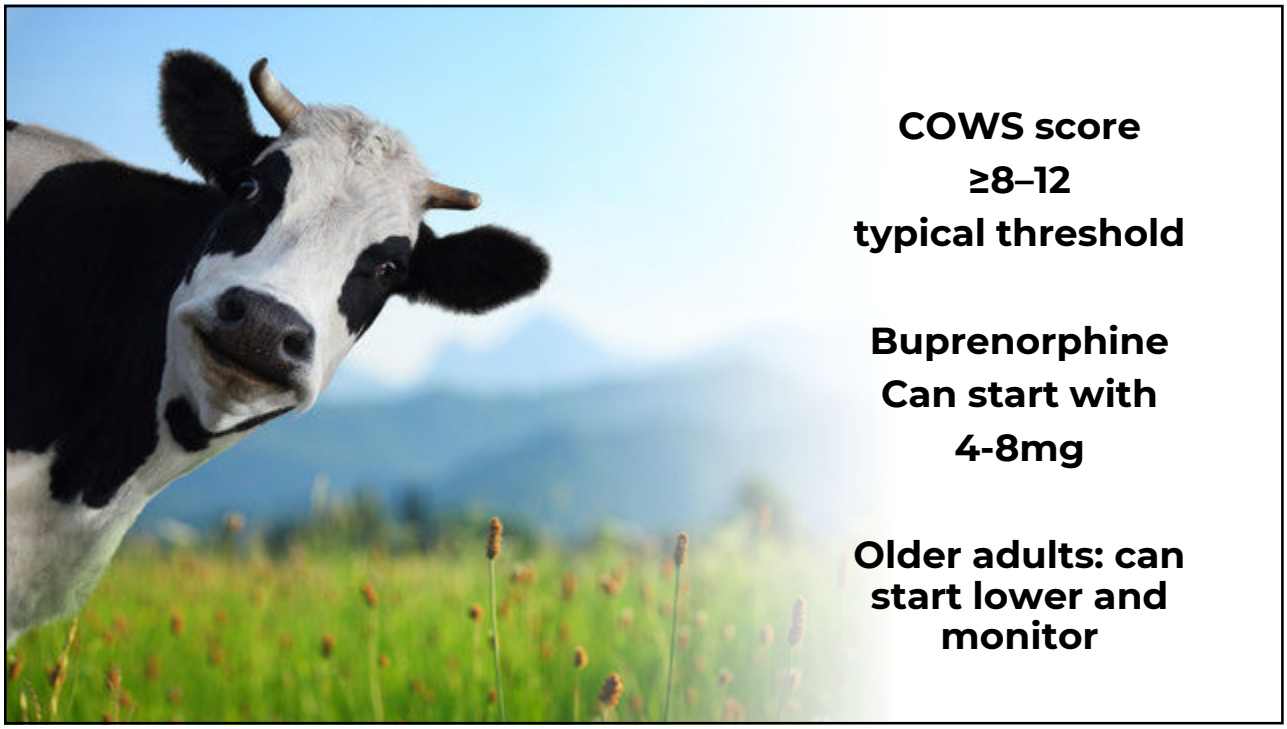
Long variable half life

QTc prolongation

Higher overdose risk in geriatric patients

Requires careful titration and monitoring

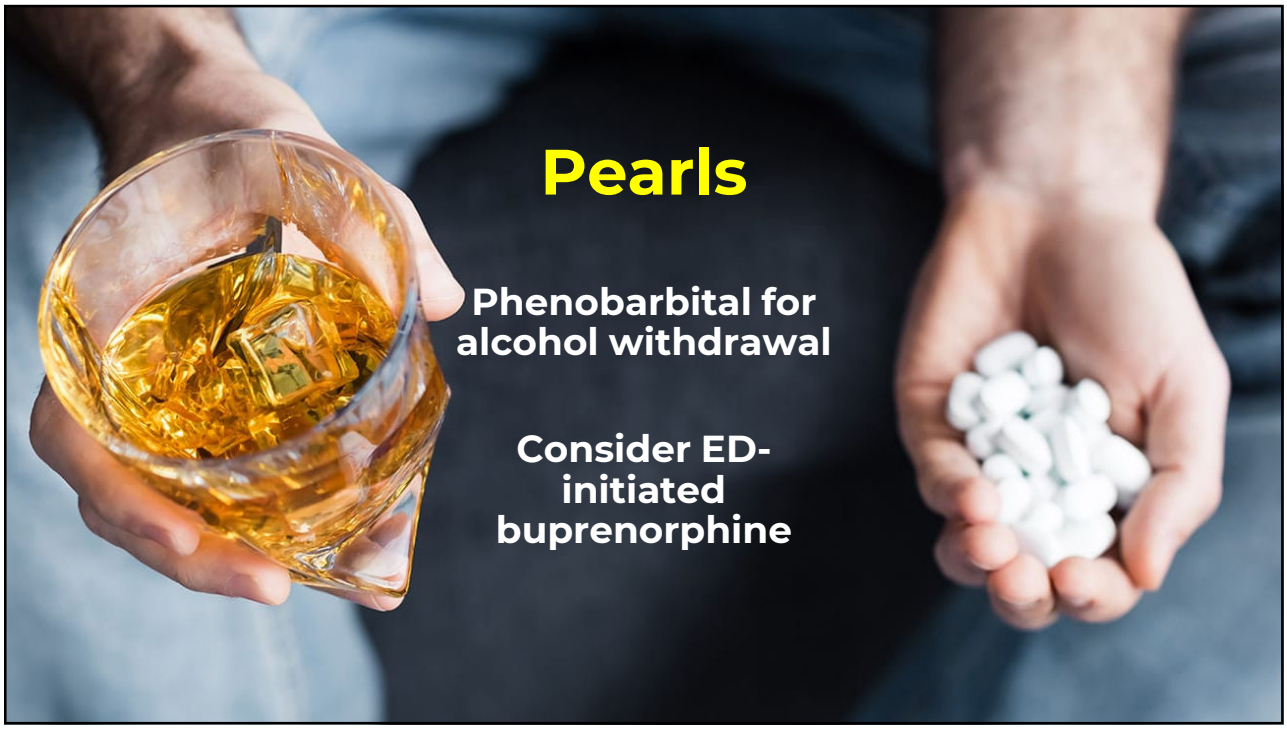
40


COWS score
≥8–12
typical threshold
Buprenorphine
Can start with
4-8mg
Older adults: can start lower and monitor

41


Pearls
Screen and Ask
Watch for atypical presentations

42


Pearls
Phenobarbital for alcohol withdrawal
Consider ED-initiated buprenorphine

43


Pearls
Don’t just treat acute symptoms
You can prevent a repeat ED visit

44

45