

THE CARLAT REPORT

ADDICTION TREATMENT

A CE/CME Publication

CURRENT COVERAGE OF TOPICS IN ADDICTION MEDICINE

Bachaar Arnaout, MD

Editor-in-Chief

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Older Adults**

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Learning Objectives

After reading these articles, you should be able to:

1. Describe the benefits and drawbacks of using medications to treat alcohol use disorder in older patients.
2. Determine low-risk drinking limits and assess substance use in older patients.
3. Summarize some of the current findings in the literature regarding psychiatric treatment.

Alcohol Use Disorder Meds in Older Adults

Rehan Aziz, MD, FAPA

*Associate Professor of Psychiatry and Neurology,
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Dr. Aziz has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

How should we employ pharmacotherapies for alcohol use disorder (AUD) in older adult patients? There are three FDA-approved medications (acamprosate, disulfiram, and naltrexone) and two other commonly used off-label agents (gabapentin and topiramate). But these medications have no established guidelines geared specifically to older adults.

In this primer, I will try to answer the following important questions:

- Do these medications work as well for older adults?

In Summary

- Factors that complicate treating older adults with alcohol use disorder (AUD) range from comorbid medical conditions to susceptibility to adverse drug events.
- Naltrexone, the only AUD medication studied in older adults, is a reasonable first-choice option for older patients who are not currently taking opioids.
- Although FDA-approved for treating AUD, disulfiram should be avoided in older patients except under special circumstances.

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Q & A
With
the Expert

Substance Use Disorder in Older Adults

David Oslin, MD

Professor of Psychiatry, Philadelphia Veterans Affairs Medical Center and the University of Pennsylvania Medical Center

Dr. Oslin has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CATR: Let's start with diagnosis. Are there specific challenges in diagnosing substance use disorder (SUD) in older adults?

Dr. Oslin: There definitely are, and DSM criteria can be hard to apply. Older adults are more likely to drink at home, much more likely to have medical problems, and may have interpersonal issues, but they will likely have fewer work-related problems as many are retired. They're also more sensitive to the effects of substances, so their tolerance may go down.

CATR: Are there screening tools we can use to make sure we don't miss SUDs in this population?

Dr. Oslin: There is a questionnaire specific to older adults called the Michigan Alcoholism Screening Test—Geriatric Version (MAST-G) (<https://www.the-alcoholism-guide.org/michigan-alcohol-screening-test.html>), but this is a long instrument. The Alcohol Use Disorders Identification Test (AUDIT-C) is just as sensitive and has only 3 items (https://www.integration.samhsa.gov/images/res/tool_auditc.pdf).



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Alcohol Use Disorder Meds in Older Adults Continued from page 1

- Should we change the way we decide which medication to start?
- Should we adjust starting dosages and titration schedules?
- Are there specific side effects that we should watch for when treating older adults?
- Do comorbid medical conditions impact our choice of meds?

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Factors that make treating older adults more complicated

1. Older adults are more likely to have comorbid medical problems. On average, they have 2.3 chronic medical conditions, the most common being hypertension, hyperlipidemia, arthritis, heart disease, diabetes, and kidney disease (Wolff JL et al, *Arch Intern Med* 2002;162(20):2269–2276).
2. As a result, older adults take many medications. In fact, it's estimated that 20%–45% of older adults are on polypharmacy regimens, meaning they take 5 or more medications at the same time (Hosseini SR et al, *J Mid-Life Health* 2018;9(2):97–103).
3. Older adults also have decreased ability to eliminate medicines.
4. All of this makes older adults more susceptible to adverse drug events. While I can't go into every potential drug interaction, I'll consider some of the more significant ones.

The following is a med-by-med run-down of AUD meds in older adults. Because the data are limited, I may not be able to address every question to your satisfaction, but I'll do my best.

Naltrexone: Oral or extended release injectable (Vivitrol)

Naltrexone is an opioid blocker that reduces the rewarding effects of alcohol, resulting in fewer drinking days and lighter drinking; it also lowers craving. It is the only AUD med studied in older adults so far. The lone study showed that it is effective in preventing relapse in patients who resume drinking (Oslin DW et al, *Am J Geriatr Psychiatry* 1997;5(4):324–332). Naltrexone also can be a good choice for some patients with comorbid AUD and opioid use disorder (OUD), although buprenorphine and methadone have better data in treating OUD.

Naltrexone has the potential to cause liver damage, though this is very unlikely at recommended doses. More commonly, naltrexone can precipitate opioid withdrawal in patients taking opioids. Before prescribing naltrexone, make sure your older adult patients are not taking any opioids for chronic pain conditions.

Dosing in older adults: Patients should be free from opioids for 7–10 days prior to starting. We recommend beginning at 25 mg daily for 7 days, then increasing to 50 mg daily as tolerated. For extended release naltrexone, administer 380 mg IM q4weeks. The most common side effects of naltrexone are nausea and vomiting. The IM can cause injection site reactions.

Acamprosate (Campral)

Acamprosate is an attractive option for many older adults with AUD, though it has not been studied in this population. While we don't know exactly how the drug works, people who respond to acamprosate find it reduces craving.

Acamprosate is a small compound that is excreted unchanged by the kidney. You can prescribe it to patients with liver disease, but use it cautiously in patients with moderate to severe renal impairment. It has no known toxic effects on any organ and doesn't interact with other substances, so it can be a safe agent for patients who take other medications.

Dosing in older adults: The medication comes in 333 mg tablets. Whereas usual guidelines are to start at 666 mg TID, we recommend starting at 333 mg TID in older adults. If the patient doesn't have side effects, increase to 666 mg TID after 7 days. The most common adverse reactions to acamprosate are diarrhea and flatulence.

Disulfiram (Antabuse)

Disulfiram is used as a deterrent. A person who drinks alcohol while taking disulfiram will develop an aversive reaction consisting of nausea, flushing, hypotension, shortness of breath, palpitations, and confusion. This can occur up to 2 weeks after taking the medication.

I don't generally recommend using disulfiram in older adults, because the reaction can be dangerous. Disulfiram can also exacerbate medical conditions common in older persons, like heart disease, diabetes, cerebrovascular disease, chronic renal failure, and peripheral neuropathy. You'll sometimes read about the risk of psychosis, though I have never seen this side effect. Further, disulfiram can cause liver damage, and by inhibiting liver metabolism, it interacts with many drugs.

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Low-Risk Drinking Limits: What Should We Tell Older Adult Patients?

Thomas Jordan, MD, MPH

Contributing writer to the Carlat newsletters

Dr. Jordan has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

How much can our older patients safely drink? And what does “safe” or “low-risk” drinking actually mean? The National Institute on Alcohol Abuse and Alcoholism (NIAAA), which is the branch of the NIH that focuses on problems related to alcohol, has released guidelines for low-risk drinking limits in older patients. Let’s take a look at their recommendations and the rationale/evidence for them.

NIAAA recommendations

The NIAAA low-risk recommendations are based upon both daily and weekly limits. The daily limit is 4 standard drinks for men and 3 drinks for women; while the weekly limit is 14 drinks for men and 7 drinks for women. NIAAA defines a standard drink as 5 ounces of wine or 12 ounces of a 5% alcohol beer. Five ounces of wine is only about a third of a large wine glass, and craft beers are often more in the range of 6%–8% alcohol. Keep this in mind when you are trying to convert your patients’ alcohol intake into “standard drinks,” as the NIAAA definitions are quite a bit lower than what many of our patients would consider a “drink.”

The NIAAA based their recommendations primarily on a survey of 43,000 people in the community. They found that of those who were drinking within both the daily and weekly limits, only 2% qualified for an alcohol use disorder (AUD). For those drinking more than either the daily or weekly limits, 20% met AUD criteria. Of those drinking more than both limits, 50% met AUD criteria (Hasin DS and Grant BF, *Soc Psychiatry Psychiatr Epidemiol* 2015;50(11):1609–1640). It makes sense that patients who drink less are less likely to have a problem with alcohol. However, the data also tell us that up to half of people drinking more than both the daily and weekly limits did not meet

AUD criteria. Additionally, keep in mind that anyone drinking alcohol will have an increased risk of acute accidents, falls, assaults, medication interactions, sleep problems, and so on.

To complicate matters further, recent findings convincingly demonstrate that *no* level of drinking is completely safe—consuming alcohol at any level can increase the risk of cancer and cardiovascular events, leading some to argue that the NIAAA cutoff may be too lenient. This is definitely a move away from the touted benefit that moderate drinking can reduce the risk of heart disease, a statement that seems to have been exaggerated. A recent *Lancet* study from April 2018 argues for the low-risk threshold to be set at 7 standard drinks per week for anyone. Consuming more than this weekly limit was associated with increased risk of all-cause mortality, stroke, and non-myocardial infarction heart disease including hypertension, heart failure, and aortic aneurysm (Wood AM et al, *Lancet* 2018;391(10129):1513–1523).

Alcohol limits: Men vs women

Why are there different guidelines for men and women? The effects of alcohol are based upon a person’s water weight, which is the total amount of water in the intracellular and extracellular spaces (vasculature, interstitial fluid, etc). The higher the water weight, the more distributed the alcohol becomes, and the lower the blood alcohol concentration. Men generally have a higher percentage of water weight—up to 70%—while women typically contain around 60% water. Men also have more alcohol dehydrogenase, the enzyme that metabolizes alcohol, than women. So, for a man and a woman who weigh the same amount and are drinking the same amount of alcohol, the man’s blood alcohol content will be lower than the woman’s and decrease faster over time (<https://ireta.org/resources/low-risk-drinking-guidelines-where-do-the-numbers-come-from/>).

Considerations for older patients

The NIAAA identifies older adults age 65+ as a special population with their

own risks. The percentage of water weight and amount of alcohol dehydrogenase both decrease as a person ages. For that reason, the NIAAA recommends that everyone over age 65, regardless of gender, abide by the daily and weekly limits for women (no more than 3 standard drinks in a day and 7 standard drinks in a week). Also consider the individual health needs of older patients, such as their risk of falling and whether their medications may become dangerous when mixed with alcohol. If your patients have problems with memory loss, depression, or high blood sugar, be sure to screen them for alcohol problems.

Screening older patients

How do we screen older adults for alcohol problems when appointment times are already so tight? The NIAAA has a clinician’s guide supporting the Alcohol Use Disorders Identification Test (AUDIT) (<https://pubs.niaaa.nih.gov/publications/Practitioner/Clinicians-Guide2005/guide.pdf>). AUDIT is a 10-question screening tool that can be completed by the patient in the waiting room. But if the patient is already in the appointment with you, the shorter NIAAA single-item screen is the way to go—you simply ask the patient, “How many times in the past year have you had 5 or more drinks in one day (or 4 or more drinks in one day, for women and all adults older than 65)?” (Saitz R et al, *J Stud Alcohol Drugs* 2014;75(1):153–157).

If the patient has never exceeded the daily limit within the past year, then affirm your patient’s behavior and recommend continuing to stay within the limits or drinking even less (eg, for people at risk for interactions or health problems affected by alcohol—as well as pregnant patients, who should abstain from drinking completely). But if the patient has exceeded the daily limit on one or more days, this is a positive screen for at-risk drinking, and you should then assess whether your patient meets the DSM criteria for AUD. If the criteria are not met, advise and assist

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Expert Interview
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Then there's the National Institute on Alcohol Abuse and Alcoholism single-item screen based on number of drinks (see Dr. Jordan's article in this issue), which I would recommend for most practices. The key issue is for providers to feel more comfortable broaching the topic and not to assume their older patients don't drink. Many providers—both in primary care and psychiatry—are too hesitant to ask about this.

CATR: Why do you think clinicians are so reluctant to ask?

Dr. Oslin: There's the idea that they don't see substance use as frequently as in younger adults, so it's not as evident; there's an overall anxiety related to asking older adults about substance use, because providers think it's somehow disrespectful; and then there's the ageist belief that there is no need to intervene in an older adult if the person has been using a substance for many years.

CATR: Let's unpack the first reason you mentioned. Is it actually true that people give up using substances as they age?

Dr. Oslin: Yes, the prevalence rates of SUDs clearly go down with age. When you get past about 80, you're talking about alcohol and tobacco for the most part, and alcohol is dramatically decreased after age 80 (Vasilenko SA et al, *Drug Alcohol Depend* 2017;180:260–264).

CATR: What do you think are the reasons for this?

Dr. Oslin: One factor is biological. Dopamine is the one neurotransmitter that most consistently decreases as we age, so there may be less reward circuitry driving addiction as we get older. Another factor is illness. Older people accumulate illnesses like hypertension and diabetes, and this is a strong motivator for behavior change. And unfortunately, some people may not survive into older age as a result of their substance use.

CATR: Can the opposite be true for some people? We do hear about late-onset SUDs.

Dr. Oslin: Well, on the flip side, there are a lot of people in their 60s and early 70s who markedly increase their consumption of different substances once they retire. Many patients in their 60s are relatively healthy—60 is the new 40—and as they retire they have a lot of free time and sometimes increase their drinking.

CATR: What about illicit substances—do you see much use of those in older adults?

Dr. Oslin: Historically, illicit substances such as cocaine, ecstasy, and LSD have not been all that prevalent. For older adults, if they want a stimulant, they'll go to a provider and get Ritalin. If they want an opiate, they'll go to a provider and possibly get a prescription for that too. You don't have to go far to get these substances if you have a health care provider. Yet, it's true that over the last 20 years there has been an increase in illicit substance use, mostly in people in their 60s and to an extent into their 70s—the baby boomers that are now reaching that age (<https://www.drugabuse.gov/publications/drugfacts/nationwide-trends>).

CATR: What about problems related to the use of prescription drugs, like benzodiazepines and opiates?

Dr. Oslin: Yes, that can be an issue. Older adults are the largest consumers of any pharmaceuticals, and they are clearly the largest consumers of opiates and benzos in this country. So when these substances are prescribed, it is often easy to miss a developing opioid or benzo use disorder. Just because the patient has a prescription for it doesn't mean it's not a problem.

CATR: Do you have practical advice for how to distinguish appropriate use vs misuse of these agents?

Dr. Oslin: Of course, we should not be prescribing pharmaceuticals that are not benefitting patients. That's a blanket statement, and it applies to anyone. The issue is that we are not very good about taking away medications, even when we're not sure if they are helping the patient. As prescribers, we need to do a better job of demonstrating the continued value for prescribing any meds and discontinuing them when they offer no benefit.

CATR: This is often a difficult discussion to have with patients. What's a good way to broach the topic?

Dr. Oslin: I will start by saying, "I don't think this has gotten you better, and here's the evidence for it: You're not sleeping any better and you're not less anxious. We need to think about a different treatment."

CATR: So some of it comes down to measuring what we're doing and discussing that with the patient.

Dr. Oslin: Right. If you give a benzodiazepine for sleep and then don't rate that person's sleep, how can you possibly know if the medication worked? If you are going to prescribe these medicines, you should be measuring and documenting the outcomes for the target symptoms. And if the meds are not working, then taper them down and get rid of them.

CATR: Let's talk a bit about older adults' vulnerabilities to the effects of substance use, such as the risk of falls and cognitive problems.

Dr. Oslin: As we age, we are more vulnerable to a lot of things—the same amount of alcohol or the same amount of any of these substances is going to cause more impairment in an older person vs a younger one. As an example, our stability and gait can worsen as we get older, so any substance that affects gait or balance will have a larger effect. Reaction time also decreases with age. So there's more pronounced impairment while driving under the influence of most of these substances as we get older.

“The most effective treatment for older people who are at-risk drinkers is brief intervention—giving direct advice that's relevant to the patient. What we run into with older adults is they have no idea that their glass of wine interferes with their antihypertensives or antibiotics. If we show that substance use is tied to the domains that are important to them, then we can assist them in strategies to reduce or change that behavior.”

David Oslin, MD

Expert Interview

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CATR: And there's also the issues of interactions with prescribed medications.

Dr. Oslin: Exactly. The other large vulnerability is that the average older adult is taking 5 prescribed medications, and alcohol has the most drug-drug interactions of any substance. For example, it can affect changes in metabolism, which is why if you have a patient on something like warfarin (Coumadin), you have to be careful as alcohol dramatically affects its metabolism and the dose required for appropriate anticoagulation. Alcohol can change target responsivity, which is why you shouldn't drink and be on an antidepressant—the alcohol will lower the antidepressant's effectiveness (Qato DM et al, *J Am Geriatr Soc* 2015;63(11)2324–2331). Alcohol counters the effects of antidepressants not from a metabolic perspective, but just from hitting the system from two different directions—an antidepressant and a depressant.

CATR: Let's shift and talk about psychosocial factors. Are there stressors that can specifically impact substance use in older adults?

Dr. Oslin: The things that are relevant for a 70-year-old are very different than those relevant for a 30-year-old. The big struggles later in life are generativity: What am I doing with my life? How am I contributing to society? What's my role? Of course, there are the external losses: the grief that people go through as they age when people around them are dying. And then there is the overall change in social fabric. For most of our adulthood, our social lives are centered around our employment (plus other activities to an extent, like church). But in older adulthood, you are no longer occupied for the 8 hours a day or 60 hours a week that you used to put into work.

CATR: So grief, isolation, and boredom can become big issues.

Dr. Oslin: Yes. Some people are successful at navigating that and some people are not. And then there's loss of function: difficulty driving at night, pain, arthritis, sleep disruption, changes in sexual function. There's a loss of independence from no longer being able to do things that you could do when you were 40.

CATR: How can this knowledge guide our psychosocial interventions in treating older adults?

Dr. Oslin: The big issue for older adults is the time and effort needed to work a recovery program. If you are 62, it may not be a big deal to do 90 meetings in 90 days, but if you are 72, going to a meeting every day is probably not going to be as easy depending on how healthy you are. We published a paper a couple of years ago demonstrating that older adults were much less likely to engage in traditional group-oriented activities such as AA (Oslin DW et al, *Addict Behav* 2005;30(7):1431–1436). It can also be tougher to relate to others. If a person is 70 and lives in a small town, and the only local AA meeting has members that are younger and have different issues and comorbidities, then the person might not want to go to that group. So those are things that we need to be cognizant of.

CATR: What about formal outpatient treatment, like an intensive outpatient program (IOP)?

Dr. Oslin: That's challenging as well. It's really hard for an older adult to sit through 4 hours of programming a day or to get to an IOP 4 or 5 days a week. Most older adults would much prefer individual treatment; that comes out over and over again in most studies (http://www.aa.org/assets/en_US/p-48_membershipsurvey.pdf). Individual treatment is not the mainstay of what we deliver, but it is the preferred method for most people.

CATR: What about older adults who may not have a full SUD, but are using here and there or drinking more than is healthy—the so-called at-risk users?

Dr. Oslin: The most effective treatment for older people who are at-risk drinkers is brief intervention. The key factor here is giving direct advice that's relevant to the patient. For many patients, reducing the drinking isn't the important thing; it's getting better control of their diabetes or hypertension, etc. So this brief intervention is a way to show that the substance use is tied to the domains that are important to the person. Then we can help form strategies to reduce or change that behavior.

CATR: That's interesting. Patients don't commonly make these connections to their general health.

Dr. Oslin: Correct. What we run into all the time with older adults is they have no idea that their glass of wine, for instance, interferes with their antihypertensives or their antibiotics. Just learning and having that direct conversation helps them realize that they need to not drink.

CATR: And again, you are relating to the at-risk population that may not even have a bona-fide SUD, correct?

Dr. Oslin: Exactly. It is education in a way, but it includes very direct advice to connect with patients' goals. Most patients are not coming to us and saying, "Oh, I'm worried about my glass of wine at night and whether I should change that behavior." It would be very rare for a provider to hear that kind of question. So tying it to something that's relevant to the patient is really important.

CATR: Thank you very much for your time, Dr. Oslin.



Low-Risk Drinking Limits: What Should We Tell Older Adult Patients?

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the patient to cut down or quit drinking. If the criteria are met, then start AUD treatment and refer the patient if needed.

Many older patients may say they've had the same pattern of alcohol use for decades—that can be a big barrier to recovery in their mind. But the first hope

for recovery may start with you. Linking to appropriate resources (including age-specific 12-step groups), employing motivational interviewing techniques, and using appropriate medication management (such as naltrexone and acamprosate) for AUD are all good first steps to take.

CATR VERDICT: NIAAA has guidelines on low-risk drinking limits, including for older adults. Yet "low risk" does not mean "no risk." Know how to educate your older adult patients and tailor your interventions appropriately.

OPIOIDS

Opioids Not Superior to Other Medicines for Some Chronic Pain

REVIEW OF: Krebs EE et al, *JAMA* 2018;319(9):872–882

Rising rates of opioid overdose deaths have sounded alarm bells over opioid prescribing practices for chronic pain. Unfortunately, and despite the absence of quality data on their risks vs benefits, long-term opioid management has remained a common approach to managing chronic musculoskeletal pain. *CATR* covered this topic in the 2018 May/June issue (See: “Treating Chronic Pain When There’s Addiction: A Primer”).

This study examined long-term outcomes in chronic pain with opioid vs non-opioid treatment. Researchers conducted a 12-month randomized trial evaluating patients who—despite analgesic use—had moderate to severe chronic back pain or hip/knee osteoarthritic pain. Patients were recruited from Veterans Affairs primary care clinics in Minneapolis, Minnesota between 2013 and 2015.

The study compared opioid and non-opioid therapy. Patients in each group were prescribed multiple medications over 3 steps. In total, 240 patients were randomized, with a mean age of 58.3 years; females made up 13% of the group.

In the opioid group, the first phase was immediate release morphine, oxycodone, or hydrocodone/acetaminophen. Second- and third-step options included sustained action morphine and transdermal fentanyl.

For the non-opioid group, the first stage was acetaminophen or an NSAID. Second- and third-phase choices comprised adjuvants, such as gabapentin or nortriptyline; topical analgesics; and drugs such as duloxetine and tramadol.

Outcomes measured included the impact of pain on daily functioning, rated on the Brief Pain Inventory [BPI] interference scale; pain intensity on the BPI severity scale; and adverse

medication-related symptoms. The BPI interference scale records the influence of pain on activities like sleep, walking, relationships, work, and life enjoyment. For both BPI scales, the range is 0–10, with higher scores indicating worsened functioning or higher pain intensity.

Over 12 months, the groups did not significantly differ on pain-related function. The mean BPI interference was 3.4 for the opioid group and 3.3 for the non-opioid group. Unexpectedly, the non-opioid group reported significantly less pain intensity at 12 months, with a BPI severity of 4.0 for the opioid group and 3.5 for the non-opioid group. Adverse medication-related symptoms were significantly more common in the opioid group.

CATR’S TAKE

The noteworthy result here is that chronic pain patients on opioids may not be any better off than those taking alternative agents. While psychiatrists are not the primary treaters of musculoskeletal pain, the current opioid crisis has had wide-ranging impact, and there are calls for a multipronged approach. As such, and since many patients develop opioid dependence after long-term opioid treatment for chronic pain, we should be ready to share these results with our patients and medical colleagues.

—*Rehan Aziz, MD.* Dr. Aziz has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CANNABIS

Effects of Cannabis Use on Smoking Cessation

REVIEW OF: Weinberger AH et al, *J Clin Psychiatry* 2018;79(2):17m11522

When counseling your patients to quit smoking, you may also want to consider asking them about their past marijuana use. Results from a recent study suggest that there may be a correlation between cannabis and tobacco smoking.

Analysis of longitudinal data of almost 35,000 adult study participants, gathered during two “waves” (2001–2002 and 2004–2005) of the U.S. National Epidemiologic Survey on Alcohol and Related Conditions, found that past cannabis use was associated with an increase in cigarette smoking initiation, persistence, and relapse.

In the study, cannabis use was associated with a 2.9-fold and 4.4-fold increased risk of new cigarette use on either a daily or non-daily basis, respectively, compared to those without exposure to cannabis in the previous year.

Among former smokers, past cannabis use was associated with increased relapse rate: 4.18 times more ex-smokers returned to daily smoking and 5.24 times more ex-smokers returned to smoking on a non-daily basis compared to those who had not used cannabinoids in the past 12 months.

Past cannabis use was also associated with difficulty quitting tobacco: Among daily cigarette smokers, past cannabinoid use was associated with decreased odds of smoking cessation by 43% compared with non-cannabis users. Even when demographics and a history of psychiatric disorders were taken into consideration, associations of cannabis use remained significant for the initiation of daily smoking among prior nonsmokers; relapsing to a daily use pattern among former ex-smokers; and difficulty quitting among daily smokers.

CATR’S TAKE

This study provides some interesting data showing that people who use cannabis are more likely to also smoke tobacco. Tell your patients that if they’ve used cannabis in the past, quitting tobacco may be more of a challenge than usual. This will set the stage for a discussion of the various smoking cessation agents available, and it might increase your patients’ motivation to accept treatment.

—*Donna Lisi, PharmD.* Dr. Lisi has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CE/CME Post-Test

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Below are the questions for this month's CE/CME post-test. This page is intended as a study guide. Please complete the test online at www.carlataddictiontreatment.com. Note: Learning objectives are listed on page 1.

- Older adults are more likely to have comorbid medical problems for which they are prescribed medications, making them more susceptible to adverse drug events. According to a 2018 study, what estimated percentage of older adults are on polypharmacy regimens (5 or more medications at the same time)? (LO #1)
 a. 5%–18% b. 20%–45% c. 50%–65% d. Over 68%
- Older adults with substance abuse disorders are more likely to engage in group-oriented programs like AA rather than individual treatment. (LO #2)
 a. True b. False
- Your 72-year-old patient has comorbid alcohol use and opioid use disorder. According to Dr. Aziz, which medication would be a good choice as long as he is free from opioids for 7–10 days prior to starting it? (LO #1)
 a. Gabapentin b. Topiramate c. Naltrexone d. Disulfiram
- According to a 2018 study, what effect did past cannabis use have on the relapse rate of former cigarette smokers? (LO #3)
 a. Cannabis had no effect on ex-smokers returning to daily smoking
 b. Ex-smokers who used cannabis were about 2 times more likely to return to daily smoking
 c. Ex-smokers who used cannabis were about 4 times more likely to return to daily smoking
 d. Ex-smokers who used cannabis were about 6 times more likely to return to daily smoking
- Although topiramate has been shown to help in treating alcohol use disorder, it's best avoided in older adults due to risks such as cognitive dysfunction as well as interactions with other common medications. (LO #1)
 a. True b. False

Alcohol Use Disorder Meds in Older Adults

Continued from page 2

Patients who have been taking disulfiram with positive results may feel strongly about continuing it. It could also be used in older patients who are otherwise healthy and taking few medications. Overall, it's best avoided except in special circumstances.

Dosing in older adults: Disulfiram should be started after the patient has abstained from alcohol for at least 12 hours. Dosing in older adults may need to be on the lower side. The initial dose I favor is 250 mg/day. After 1–2 weeks, the dose can be reduced to 125 mg/day for maintenance therapy (Jacobson SA, *Clinical Manual of Geriatric Psychopharmacology*, 2nd Edition. Washington DC: American Psychiatric Association Publishing; 2014). Since disulfiram can be sedating, give it at bedtime. Supervised ingestion is likely key to ensuring compliance (Fuller RK and Gordis E, *Addiction* 2004;99(1):21–24).

Gabapentin (Neurontin)

Gabapentin has been associated with increased abstinence and reduction in heavy drinking, but it has not been studied for this use in older adults. Side effects include somnolence, headache, dizziness, and ataxia. Some individuals have been noted to misuse gabapentin (See *CATR* Jan/Feb 2018, "Prescribing Gabapentin for Substance Use Disorders"). It has few significant drug interactions, though lower doses should be used in those with renal impairment. Because of its favorable profile, it can be a good option for older adults with AUD, especially those with comorbid pain or anxiety. Be sure to start low and go slow, as gabapentin is sedating and can increase the risk of falls.

Dosing in older adults: Gabapentin can be started at 100 mg/day or BID and gradually increased, based on the patient's response. I usually don't go higher than 300 mg TID.

Topiramate (Topamax)

Topiramate has shown benefit in AUD, but it's best avoided in older adults due to risks of cognitive dysfunction, sedation, falls, osteoporosis, kidney stones, metabolic acidosis, and weight loss. Its serum concentration can also fluctuate due to interactions with other common medications: Lithium and amitriptyline can increase topiramate level, while valproate can decrease it (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2861844/>).

CATR VERDICT:

For most older adults with AUD, I recommend starting with naltrexone, as it's the only AUD medication studied in this population, but it won't be a good choice for everyone. Acamprosate is a reasonable second option. Gabapentin may also be useful. Disulfiram and topiramate should generally be avoided.

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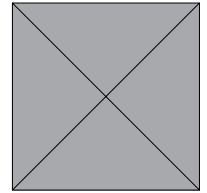


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This Month's Focus:
Addiction in Older Adults

**Next month in *The Carlat Addiction Treatment Report*:
Opioid Addiction**

Note From the Editor-in-Chief

Addiction spares no age group, but it often goes undetected in older adults age 65 or older, and its treatment poses age-specific challenges. In this issue, we interview Dr. David Oslin to unpack some of these challenges and talk about screening tools, physiological changes, and psychosocial stressors, as well as general treatment approaches in older adults with substance use disorders.



We also hear from Dr. Rehan Aziz, who offers some handy recommendations on using meds to treat alcohol use disorder in older adults. We chose to focus on alcohol use not only because it's common, but also because there are relatively fewer age-specific issues in prescribing meds for opioid and nicotine use disorders.

We then take on the perennial question: How much alcohol is too much? Dr. Thomas Jordan addresses this controversy and includes some sobering recent data, then helps us understand how to screen older adults (as well as other patients) for at-risk drinking and tailor our interventions.

Finally, we summarize two recent studies from clinical literature—one reporting that non-opioids may be just as effective as opioids for chronic pain, and the other finding that past cannabis use is associated with becoming addicted to tobacco.

We hope you find these articles informative. Please write with your feedback!

Best,
Bachaar Arnaout, MD

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