



# The Brown University Geriatric Psychopharmacology UPDATE

THE PREMIER MONTHLY FORUM ABOUT THE USE OF PSYCHOTROPIC MEDICATIONS IN THE ELDERLY

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We've redesigned *The Update* in an effort to make the information you need even easier to navigate. Notice the Précis boxes with a brief snapshot of each research piece and an increase in graphic and boxed elements to highlight key findings.

— Karienne Stovell, Executive Editor

## SUBSTANCE ABUSE

### Late-life alcohol abuse: Finding solutions to a hidden medical problem

**Y**ou might expect an illness that causes brain damage, cardiomyopathy, hypertension, liver disease, disabilities and social isolation to command attention as a pressing problem. Unfortunately, healthcare providers

#### précis

- Late-life alcohol abuse under-diagnosed
- Aging-related depression often responsible
- Routine screening recommended

tend to overlook and undertreat late-life alcohol abuse, according to David W. Oslin, M.D., assistant professor at the University of Pennsylvania School of Medicine and the Philadelphia Veterans Affairs (VA) Medical Center.

In his recent literature review, Oslin notes that while about 50 to 60% of older adults never drink, an estimated 1 to 15% of community-dwelling older people drink too much. Elderly inpatients in general medical and psychiatric settings show higher rates. Studies in VA nursing homes for example, such as Oslin's 1997 study (*Int J Ger Psy*; 12:825-832) show that as many as a fourth to one half of residents have a history of alcohol abuse. A 1995 study by Joseph et al. (*J Am Ger Soc*; 43:368-373), also found that 49% of VA nursing home residents had a lifetime diagnosis of alcohol abuse or dependence.

Yet, the literature "suggests that physicians on the whole have done a very bad job of identifying alcohol problems in older  
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## ELECTROCONVULSIVE THERAPY

### Pros and cons of using ECT in the elderly

#### Severely depressed elderly patients may respond better to ECT than to antidepressants

**E**lderly patients with major depressive disorder (MDD) experienced a good acute therapeutic response to both electroconvulsive therapy (ECT) and antidepressant therapy in a research trial published in the *Journal of ECT*.

#### précis

- 51 patients age 60 or older with major depressive disorder
- Acute response to ECT better than antidepressants
- Researchers assert that ECT is an effective and safe treatment in elderly patients
- Rate of relapse/rehospitalization high in both ECT and antidepressant groups

However, the major finding in this study was the relatively high rehospitalization rate, says Martti Huuhka, M.D., lead investigator.

"The risk of relapse is considerably high in severe depression in the elderly in spite of the treatment method," Huuhka told *The Update*. "Thus, careful follow-up after discharge is needed."

Huuhka is a member of the Department of Geriatric Psychiatry at the Tampere University Hospital in Pitkaniemi, Finland.

Participants were 51 patients age 60 or older — nine men and 42 women — who were consecutively admitted to the hospital with MDD. Thirty patients were treated with ECT, and 21 with antidepressant therapy. All met the DSM-IV criteria for MDD. Thirteen had psy-  
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a day) in one of two trials (listed as Study Reports Nos. GAL-INT-3 and GAL-INT-7 from the Janssen Research Foundation). Patients were included in these studies if they had a history of gradual and progressive cognitive decline, were diagnosed with probable AD and had mild to moderate dementia.

For the continuation trial, patients (N=491; 73.1 ± 0.37 years of age) received galantamine 12 mg b.i.d. for an additional 24 months (for a total exposure of 36 months). A total of 314 patients completed the entire study, for a mean exposure time of 921.4 ± 9.95 days.

During the combined 36-month period, patients were assessed using the Alzheimer's Disease Assessment Scale – Cognitive sub-

scale (ADAS-cog) at baseline and months 6, 12, 24 and 36. Over the first six months of treatment, some improvement in cognition (decrease in ADAS-cog score) was observed that was maintained to the 12-month time point.

After 36-months of treatment, some cognitive decline was experienced (ADAS-cog scores increased by 10.8 ± 0.54 points, LOCF analysis for 339 patients). However, these changes in ADAS-cog scores were less than those estimated for these patients if they had not received treatment (projected by the Stern equation as an increase of 22 points). This indicated that continuing galantamine treatment slowed the deterioration of cognitive abilities in these patients, gaining approximately 18 months of preserved

cognitive function.

Long-term galantamine exposure was fairly well tolerated in this population. Treatment-emergent adverse events included agitation (16.1%), insomnia (12.4%), fall (11.2%), and urinary tract infection (10.2%). "Within the limitation of this open-label extension trial, there appears to be a potential for prolonged benefit with galantamine therapy for patients with AD compared with lack of treatment over time," concluded the authors. ■

\*Funded by Janssen.

Pirttila T, Wilcock G, Truyen L, et al.: Long-term efficacy and safety of galantamine in patients with mild-to-moderate Alzheimer's disease: multicenter trial. *Eur J Neurol* 2004; 11(11):734-41. E-mail: tuula.pirttila@kuh.fi.

## LATE-LIFE ALCOHOL ABUSE

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adults, and a lot of it has to do with the biases that we all have," Syed Pirzada Sattar, M.D., Medical Director of the Substance Abuse Treatment Program at the Omaha Veterans Affairs Medical Center told *The Update*.

One reason drinking problems go undiagnosed, Sattar says, is that some of the DSM-IV criteria for alcoholism lack relevance for many older adults: "They're not employed, so you can't really look at employment problems. They may not drive, so there's less possibility of having DUI and other legal problems. Often, they have very little social interaction." In addition, doctors spend less time with patients who are older, making them less likely to elicit drinking information.

### When less is more

Drinking poses greater risks for older people. The same amount of alcohol raises their blood alcohol levels more than younger drinkers' due to aging-related loss of body water. Aging also boosts the central nervous system's sensitivity to alcohol, and the elderly often take medications that interact with alcohol. For these reasons, seniors whose alcohol intake has not changed may start experiencing problems.

Despite the perils of overindulgence, studies show that moderate drinking brings health benefits such as preventing cardiovascular disease and some types of dementia. This begs the question: What's moder-

ate? The National Institute on Alcohol Abuse and Alcoholism recommends, for men age 65 or over, no more than one standard drink per day, seven per week, or two on any drinking day, and less for women. A standard drink consists of 12 ounces of beer, 5 ounces of wine or 1½ ounces of 80-proof spirits. Sattar says women should stop at half the men's limits.

### Identifying problem drinkers

Most older alcoholics started imbibing as young adults, but one in three start late in life, often after a stressor like retirement, major illness or bereavement. The losses of aging may prompt relapse, despite years of sobriety. Late-onset drinkers are likelier than early-onset ones to quit drinking.

To unearth seniors' alcohol problems, Oslin calls for screening to become part of routine health care. Clinicians should investigate patients' alcohol use annually, before they begin new medications, and when problems appear that could be alcohol- or medication-related.

Because excess drinking can aggravate existing medical problems — including high blood pressure, diabetes, heart conditions and ulcers — healthcare providers should evaluate patients' alcohol use when such conditions worsen, says Sattar. Patients whose blood pressure and heart rate spike after a day or two in the hospital may be undergoing withdrawal.

Christopher Barrick, Ph.D., a counseling psychologist at the University at

## The CAGE Questionnaire\*

- 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 had a drink first thing in the morning to steady your nerves or get rid of a hangover (**eye-opener**)?

\* "Yes" answers to two questions, or perhaps even one, warrant a closer look.

Buffalo's Research Institute on Addictions, recommends that busy clinicians use the CAGE questionnaire (above) to facilitate screening. It consists of four simple, easy-to-remember questions. "People don't feel like they're getting the third degree" with it, he told *The Update*. Providers without expertise in addiction issues should refer patients to addiction specialists when needed.

### Psychosocial interventions

Most studies of addiction treatment have excluded patients over age 65. Yet, Oslin writes that "contrary to popular beliefs, older adults are quite amenable to treatment, especially in programs that offer age-appropriate care with providers who are knowledgeable about issues of aging." They respond as well, if not better than, younger drinkers to psychosocial interventions. Barrick says they prefer a

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practical, solution-oriented approach. Treatment may involve cognitive-behavioral therapy, group or family therapy, or self-help groups.

Cognitive-behavioral therapy helps maintain sobriety by teaching patients alcohol-free ways to deal with stressors. Barrick says, "It very often will teach coping skills and ability to manage problems in a way that the person simply didn't have in their arsenal before."

Group and family therapy also deter relapse and may be easier to find due to cost issues, explains Barrick. Particularly with older people, he says these therapies can focus on rebuilding or building a support network. Groups tailored to older adults work best.

Barrick finds that self-help groups like Alcoholics Anonymous don't help everyone but work "really well" for some. Groups vary in character and style, so patients should shop around to find one that suits them.

## Pharmacotherapy

For older drinkers needing detoxification, Oslin deems pharmacotherapy "the gold standard." He prescribes the benzodiazepine oxazepam due to its low potential

for hepatotoxicity. Comorbid conditions can complicate the process, however.

After detoxification, medication, coupled with psychosocial treatment, can help avert relapse. For instance, disulfiram makes drinking repugnant by unleashing vomiting, nausea, facial flushing and other symptoms if alcohol is consumed. Despite its general usefulness, experts seldom use it for seniors, because the reaction it causes might overtax their bodies.

Two newer options, naltrexone and the recently approved acamprosate, work differently from disulfiram in that they do not make drinkers sick. "We've got a lot of experience with naltrexone" in older adults, Oslin told *The Update*, but we know little about acamprosate in this population.

Naltrexone, an opioid antagonist, makes drinking less pleasurable and curbs cravings. Oslin begins patients at 50 mg once a day. He halves that dose for women if side effects occur. People with acute hepatitis or liver failure should not take naltrexone. The drug will block analgesia in patients who take opiates for pain.

The FDA approved acamprosate last July to help alcoholics stay sober. Treatment should begin right after detoxification when the patient has abstained for

seven days and should continue if relapse occurs. For older patients, Oslin recommends 1–2 g per day, divided into three or four doses. Although patients with significant kidney failure should avoid acamprosate, the drug provides an option for those with mild to moderate liver disease.

According to Oslin, new medicines for alcoholism remain several years off, but two existing ones are generating research interest for their potential to control drinking — topiramate, which is now used to treat seizures, and ondansetron, a selective 5-HT<sub>3</sub> receptor antagonist, currently used for its antiemetic properties.

Oslin observes that alcoholics treated as inpatients often leave the hospital on medications such as antidepressants or mood stabilizers, but "rarely do they leave with medicine specifically to address the alcohol addiction."

Providers seem uneasy with prescribing medicine to target alcoholism, he told *The Update*, adding "it's a shame because patients could be benefiting from it." ■

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Oslin DW: Late-life alcoholism: Issues relevant to the geriatric psychiatrist. *Am J Geriatr Psychiatry* 2004; 129(6):571-583. E-mail: oslin@mail.med.upenn.edu

## USING ECT IN THE ELDERLY

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chotic features. Patients with dementia, substance abuse issues and depression caused by organic factors were excluded.

Those in the ECT group had an average of 3.3 previous hospitalizations; 10 patients had been hospitalized within the 12 months prior to the index episode. The antidepressant group had an average of 2.6 previous hospitalizations, with two patients having been hospitalized in the 12 months prior to the index episode.

Thirteen of the 30 ECT patients had concomitant antidepressant medications and 12 had antipsychotic medications during the course of ECT.

The acute response to ECT was good, says Huuhka. However, 13 of the 30 participants in the ECT group (43%) and eight of 21 participants in the antidepressant group (38%) were rehospitalized within the year. Six of the 13 participants in the ECT group and one of the 8 participants in the antidepressant group were rehospitalized during the first month after discharge.

### Antidepressant use in study by Huuhka, et al.

Mirtazapine	30 – 45 mg/day
Venlafaxine	75 – 300 mg/day
Citalopram	20 – 40 mg/day
Nortriptyline	50 – 125 mg/day
Reboxetine	4 – 8 mg/day
Fluoxetine	20 mg/day
Doxepin	150 mg/day
Mianserin	30 – 90 mg/day

Huuhka says this did not surprise her.

"The rehospitalization rate was about as expected," says Huuhka. "It is in line with the findings of Sackeim, et al. (*JAMA* 1993), where around 60% of ECT-patients relapsed in one year follow-up."

All patients in both groups (except one in the ECT group) continued to receive antidepressant treatment throughout follow-up (see box above for details).

The outcome of MDD in elderly patients is influenced by many factors, including treatment methods, physical health and social factors. It has been said that one-third of the elderly depressed get better, one-third

stay the same, and one-third get worse no matter what is done, Huuhka reports. Overall, the literature is mixed on prognosis and outcome for this population.

## Study methods

Huuhka began the study with the hypotheses that the primary outcome of patients treated with ECT would be better than for those treated with antidepressants, but that the rehospitalization rate would be higher for the ECT group.

ECT was administered 3 times a week with a brief-pulse, constant-current device. All the patients were treated with standard bilateral (bifrontotemporal) ECT, and the number of treatments ranged between five and 12, with an average of eight treatments. ECT was continued until patients were symptom-free, or until they had received at least eight treatments and experienced no further improvement during the past two treatments.

## Results

The MADRS total scores diminished

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