Case report / Artykuł kazuistyczny

Onset of alcohol drinking and alcohol use disorder in the eighth decade of life: a case report

Inicjacja alkoholowa i zaburzenia związane z używaniem alkoholu w ósmej dekadzie życia: opis przypadku

Soumya S. Patil, Swarna B. Nayok, Sathyanarayana M. Thimmaiah, Dhanashree Akshatha H.S.

Department of Psychiatry, Sri Siddhartha Medical College and Hospital, Tumakuru, Karnataka, India

Alcohol Drug Addict 2020; 33 (4): 363-368
DOI: https://doi.org/10.5114/ain.2020.104817

Abstract

Introduction: Alcohol use disorder (AUD) in the geriatric population is often missed although the prevalence ranges from 1.1% to 4.1%. However, the first drink in the eighth decade of life is rare. Here we report a patient who started drinking at 72 years of age and developed dependence within a year.

Case description: Mr P. was referred for alcohol dependence treatment from the Department of Surgery, diagnosed with benign prostatic hyperplasia and hypertension. He was 74 years old and had started drinking alcohol (whiskey) only in the last 2 years due to boredom. He also had suffered from postural and action tremors for the last 30 years, which decreased on drinking. Initially starting with 30 mg of alcohol once in a month due to peer pressure, he quickly developed tolerance within 1 year, requiring 60 mg

Streszczenie

Wprowadzenie: Zaburzenia związane z używaniem alkoholu (AUD) u osób w podeszłym wieku są często niedostrzegane, chociaż ich występowanie w tej populacji waha się od 1,1% do 4,1%. Rozpoczęcie picia alkoholu w ósmej dekadzie życia należy jednak do rzadkości. W artykule opisano przypadek pacjenta, który zaczął pić w wieku 72 lat i w ciągu roku uzależnił się od alkoholu.

Opis przypadku: Pan P., u którego w Klinice Chirurgii zdiagnozowano łagodny przerost gruczołu krokowego i nadciśnienie, został skierowany na leczenie uzależnienia od alkoholu. Miał 74 lata i dopiero 2 lata wcześniej zaczął pić (whisky) z powodu nudy. Pod wpływem alkoholu zmniejszały się drżenia posturalne i ruchowe, które towarzyszyły mu od 30 lat. Zaczął pić za namową kolegów – początkowo po 30 mg alkoholu raz w miesiącu. Szybko jednak (w ciągu roku) na skutek rozwoju

Correspondence to/Adres do korespondencji: Sathyanarayana Malleshwara Thimmaiah, Department of Psychiatry, Sri Siddhartha Medical College and Hospital, Tumakuru-572107, Karnataka, India, phone: +91 9880487387, e-mail address: sanamathi23@gmail.com

Authors' contribution/Wkład pracy autorów: **Data collection/Zebranie danych:** S.S. Patil, S.B. Nayok, S.M. Thimmaiah, D.A. H.S.; **Acceptance of final manuscript version/Akceptacja ostatecznej wersji pracy:** S.S. Patil, S.B. Nayok, S.M. Thimmaiah, D.A. H.S; **Literature search/Przygotowanie literatury:** S.S. Patil, S.B. Nayok

No ghostwriting and guest authorship declared./Nie występują zjawiska *ghostwriting* i *guest authorship*.

Submitted/Otrzymano: 15.02.2020 • **Accepted/Przyjęto do druku: 01.09.2020**

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about 2 to 3 times/week. It helped to reduce his boredom and tremors. At the time of our interview, his last drink was 20 days ago and he showed no withdrawal symptoms apart from non-specific sleep problems. There was no history of blackouts, falls, head injury, memory disturbances, syndromal depression, disorientation and parkinsonism, cerebellar dysfunction, alcoholic liver disease or neuropathy on examination. He also smoked tobacco for the last 10-12 years and his motivation to quit both (alcohol and tobacco) was poor.

Commentary: Boredom and health issues led to the onset of alcohol use in our patient. This further progressed to AUD. The onset at 72 years and rapid tolerance shows us that alcohol use problems have no age limits.

Keywords: Alcohol, Alcohol dependence, Older adults, Late onset, Alcohol use disorder.

tolerancji na alkohol zaczął pić 2–3 razy w tygodniu po 60 mg. Pomagało mu to zmniejszyć nudę i opanować drżenia. Ostatni raz pił 20 dni przed konsultacją, nie wykazywał jednak żadnych objawów abstynencyjnych, poza niespecyficznymi problemami ze snem. W wywiadzie nie stwierdzono epizodów utraty przytomności, upadków, urazów głowy, zaburzeń pamięci, objawów depresji, dezorientacji i parkinsonizmu, dysfunkcji móżdżku, alkoholowej choroby wątroby ani neuropatii. Od 10–12 lat pan P. palił tytoń. Miał słabą motywację do zaprzestania używania obu substancji – alkoholu i tytoniu.

Komentarz: Nuda i problemy zdrowotne spowodowały, że pacjent zaczął spożywać alkohol. Picie doprowadziło do zaburzeń związanych z używaniem alkoholu (AUD). Rozpoczęcie picia w wieku 72 lat i szybki rozwój tolerancji na alkohol pokazały, że problemy z używaniem alkoholu nie mają ograniczeń wiekowych.

Słowa kluczowe: alkohol, uzależnienie od alkoholu, osoby starsze, późny początek, zaburzenia związane z używaniem alkoholu.

■ Introduction

The harmful effects of alcohol use disorder (AUD) often differ according to the age of onset. They are considered to be of "late onset" when AUD starts at least after 45 years. This may have a different course and prognosis, modified by various social factors [1, 2]. Studies evaluating AUD in the geriatric population show prevalence to be 1.1% to 4.1% in those above 60 years of age [3]. However, the age of first drink in this population is often in the 40s [4-6]. In a qualitative study to understand the reasons related to the onset and maintenance of AUD, the oldest of the 29 persons interviewed was of 70 years of age. The time taken from the first drink to a dependence pattern varies according to several factors like the amount of alcohol used, comorbid medical disorders and social or familial stressors [6]. For the first drink to occur at 70 years of age or above is even rarer. Thus, here we report a patient who experienced the onset of alcohol use and subsequent AUD in his eighth decade of life.

■ Case description

Mr P. is a 74-year-old married Hindu shepherd of lower socio-economic status without formal education, who lives with his wife. He was diagnosed with benign prostatic hyperplasia (BPH) and admitted under the Department of Surgery. He had given a history of alcohol consumption and thus was referred to us. He also suffered from hand tremors. He was then diagnosed with hypertension for the first time. His elder brother has tremors of both hands and moderate postural tremors from the age of about 40 years. Like his brother, he suffered from postural and action tremors for the last 30 years, but this did not interfere in his daily work.

He started drinking Indian-made whiskey two years ago when one evening he met with one of his old friends in the market place. His friend insisted on going to a nearby bar and Mr P. agreed, with no intention to have a drink but to spend time with his friend. On further persistence by the friend, he sipped about a 10 mg equivalent of whiskey with water. He found the taste unpleasant but felt relaxed. Due to apparent boredom and tiredness, he started meeting the same friend and a few others at

bars and consuming initially 30 mg of alcohol once a month. He was surprised that alcohol reduced his tremors completely. He started drinking more often, from about twice a week gradually increasing to 5 times a week within a year. He visited bars alone. He developed tolerance rapidly within a year (about 4-6 months of regular drinking), requiring about 60-90 mg of alcohol/day to achieve desired effects like tremors relief. He also liked meeting his fellow villagers at the bar. Although shy, he found it was easier to have a conversation after drinking alcohol. When he did not drink, he experienced withdrawal symptoms of nausea, vomiting, headaches and poor sleep for 2-3 days. He knew about the harmful physical effects of alcohol but was still unable to control the urge of drinking. His wife had commented to him several times regarding his "new bad habit", which he often brushed off as a temporary indulgence.

He was himself surprised to realise how rapidly and easily it had become a need. However, financial constraints made him stop drinking for the last 20 days. No withdrawal symptoms were found at the time of consultation, apart from non-specific disturbed sleep. There was no history of blackouts, falls, head injury, memory disturbances (Hindi Mini-mental State Examination = 27/31), no history suggestive of delirium, or seizures on withdrawal or depression (Hamilton Depression Rating Scale = 3). There were no signs of fever/disorientation, parkinsonism, dementia, cerebellar dysfunction, alcoholic liver disease and neuropathy on examination. Apart from leucocytosis (15,400 cells/mm^3), his other blood parameters which included complete blood count, liver function test, renal function test, and serum electrolytes were within normal limits. His magnetic resonance imaging (MRI) brain (plain) showed normal study. Ultrasonography of abdomen and pelvis showed grade III prostatomegaly. He was diagnosed to have AUD as per The Diagnostic and Statistical Manual of Mental Disorders-version 5 (DSM-5) with essential tremors (familial). He had poor motivation to quit alcohol. Instead, alcohol helped his tremors and reduced boredom. He smoked about 4-5 beedis per day for the last 10-12 years. His son, now aged 38 years, has been drinking alcohol regularly for the last 15 years. He often had decreased sleep and appetite when not drinking. However, he did not suffer from tremors in general, but only during probable alcohol withdrawal periods. Otherwise, there was no family history of substance use, seizures or other mental disorders. The son did not stay with Mr P. who had several arguments with him regarding the son's alcohol use. Mr P. perceived alcohol use as a menace of society. He however justified his own alcohol use as a form of self-medication for tremors.

He was given thiamine prophylaxis and tablet lorazepam 2 mg (as required) for his sleep disturbances. He was started on tablet topiramate 50 mg/day as anti-craving, with the addition of tablet propranolol 10 mg/day for tremors. Topiramate was chosen primarily for its affordability (vs. acamprosate, naltrexone, or baclofen). Considering the cognitive impairments associated with topiramate, we planned of keeping track of his cognitive functions during follow-ups, with the baseline of an HMSE score of 27/30. Motivational Enhancement Therapy was applied for 5 sessions, focussing on the ill effects of alcohol and tobacco and that his tremors could be controlled by a single tablet of low dosage. His motivation had shifted from pre-contemplation to contemplation stage but locus remained external. He was also started on tablet telmisartan 40 mg/day for hypertension. The patient was offered nicotine chewing gums as replacement therapy but he refused. BPH was managed conservatively with medications with a planned surgery on a later date. He, however, did not come for further follow-up to either of the departments.

Commentary

When AUD starts after 45 years of age, it is considered to be of "late onset". Some authors take it to be as late as 60 years. However, most of those with late onset AUD take their first drink much earlier. Having a first drink is different from having AUD. Thus in this respect, there may be two subgroups in the geriatric population. One group comprises those with onset of drinking prior to 60 years of age and suffering from AUD after 60 years. The other smaller group may be those who both start drinking after 60 years of age and subsequently developed dependence. Whether genetic factors, personality, peer pressure and life stress play similar roles in these two groups is not evaluated [1, 2, 6, 7]. Late alcohol initiation might indicate the presence of other comorbid disorders (depression, late onset psychosis, dementia) or a change in life circumstances like a death of a spouse,

a diagnosis of terminal illness or retirement [1, 2, 7]. Late onset alcohol use may also be a coping mechanism for those who have lost meaning in their lives. Boredom, loneliness and lack of social support often contribute [6-8]. This is particularly seen in our patient. The elderly are also particularly susceptible to harmful effects of alcohol owing to slower metabolism from the liver, impaired cognitive functions and low water content in the body. In our patient, boredom was the initial reason to start alcohol, but relief of tremors became one of the maintaining factors. Down-playing or minimising alcohol use and its effects were also found in our patient. This has been noted elsewhere too [7]. A biological perspective is also partially apparent in the family history of Mr P. as his son suffered from probable AUD. Moreover, Mr P. had been using tobacco for almost a decade, highlighting the probability of an already existing dysregulated reward circuit [9]. In hindsight, he would have started smoking at about 60 years of age, which is also late onset. While Mr P. did not report of low mood or anhedonia at a syndromal level sufficient enough to make a diagnosis of mild depression or dysthymia, sub-syndromal dysphoric mood, coupled with boredom may lead to alcohol use in this age group [10]. A holistic geriatric treatment plan of alcohol dependence management with slow detoxification phase and anti-craving medications, management of medical or surgical comorbidities, environmental modification and family support often help to regain the perceived loss of control over one's life and thus reduce or stop alcohol use [8, 11, 12].

The onset of alcohol use at 72 years of age and rapid tolerance reveals that alcohol use problems have no age limits. Boredom and essential tremors probably contributed to it. However, without biological predisposition, dependence may not have started. This case report shows the interplay between biopsychosocial factors. It also highlights the importance of evaluating for possible alcohol use and abuse in patients older than 70 years of age.

Conflict of interest/Konflikt interesów

None declared./Nie występuje.

Financial support/Finansowanie

None declared./Nie zadeklarowano.

Ethics/Etyka

The work described in this article has been carried out in accordance with the Code of Ethics of the World Medical Association (Declaration of Helsinki) on medical research involving human subjects, Uniform Requirements for manuscripts submitted to biomedical journals and the ethical principles defined in the Farmington Consensus of 1997.

Treści przedstawione w pracy są zgodne z zasadami Deklaracji Helsińskiej odnoszącymi się do badań z udziałem ludzi, ujednoliconymi wymaganiami dla czasopism biomedycznych oraz z zasadami etycznymi określonymi w Porozumieniu z Farmington w 1997 roku.

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