postoperative pulmonary complications, and better chances of long term graft patency.[3 4 7 16 18] Patients who continue to smoke but in whom the arterial disease is not yet critical should be reminded that the operative risk and chance of bypass failure remain too high to justify surgery. Nevertheless, if the disease progresses no smoker should be denied urgent surgery to prevent amputation, stroke, or death.

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Misuse of alcohol or drugs by elderly people

May need special management

Between 5% and 12% of men and 1-2% of women in their 60s are problem drinkers.[1] The rates are substantially higher among hospital outpatients and people attending clinics.[2] A study of 1070 elderly men and women selected from general practice lists showed that nearly one fifth of both sexes who were regular drinkers exceeded the recommended limits.[3]

Both the quantity of alcohol drunk and the frequency of drinking by elderly men—and so the frequency of problems related to alcohol—are higher than those in elderly women.[4] On average elderly people drink less than younger people, but aging does not always modify drinking behaviour, and excessive alcohol use may simply be carried into old age. The trend for elderly people to reduce alcohol consumption seems to be less noticeable in women. Elderly people are less tolerant of the adverse effects of alcohol owing to a fall in the ratio of body water to fat, a decreased hepatic blood flow, inefficiency of liver enzymes, and reduced renal clearance.[5]

Misuse of other substances is uncommon among elderly people, though the numbers may be underestimated.[6] Problems are recognised to occur both with over the counter remedies, such as laxatives, analgesics, and antihistamines and with prescribed drugs, including diuretics, benzodiazepines, and antidepressants. On the other hand, many elderly people may underuse prescription medicines important for their health. Home medicine cabinets often contain dozens of containers of over the counter remedies, many of which are harmful to patients with cognitive impairment. When new drugs are added, the old ones may not be discarded. A three year prospective study of new elderly patients seen at home showed that a third were taking four or more different preparations daily.[7]

Alcohol and drug problems in elderly people are easily missed. Doctors may fail to consider substance misuse in a population in which there are plenty of urgent medical matters. Failure to record alcohol and drug histories accurately will, nevertheless, slow identification of any problems. When long term misuse of substances is identified the responsibility for treatment is often put on to the general practitioner. Some health professionals harbour a misguided belief that older people should not be advised to give up established habits.[8] Relatives—eager to safeguard the reputation of the family—may try to deny the existence of any problem. History taking can be difficult in confused patients. Old people may find difficulty in recalling past average consumption, especially if they are chronic misusers of alcohol. Elderly patients may be reluctant to answer potentially embarrassing questions, and often doctors do not ask the relevant questions because they mistakenly believe that older people, and especially older women, rarely drink.

As a general rule chronic alcohol misuse is associated with longstanding psychopathology and a family history of alcoholism. Medical problems such as hepatic cirrhosis and peripheral neuropathy are prominent with longstanding alcoholism, and the mortality is high. Misuse of recent onset tends to be precipitated by life stressors, such as widowhood, reduced social support, and medical illness. Late onset drinkers are usually more psychologically stable than chronic drinkers, their alcohol consumption is generally less excessive, and they tend to stay in treatment for longer periods.[9]

Misuse of drugs and alcohol, alone or in combination, may lead to patients presenting with poor hygiene, falls, incontinence, cognitive impairment, hypothermia, or self neglect. Common complaints such as insomnia, loss of libido, depression, and anxiety may be used by elderly people to justify heavy drinking. Many old people may not acknowledge that taking a tot of rum or whisky in tea and coffee is ingesting alcohol; they find such a drink comforting, thus reinforcing its further use.[10]

To detect substance misuse in this age group appropriate screening measures are necessary.[11] A full history of use of alcohol and other drugs should be obtained routinely, and this should include questions on amounts taken in tea and coffee. The current recommendations for safe limits of alcohol consumption may need to be adjusted downwards for elderly people because of their particular vulnerability to its toxic effects. Patients should be warned about the hazards of self medication with over the counter remedies or prescription drugs, or both, and possible interactions with alcohol.[12]

Hospital staff need more education on substance misuse and its complications. A hospital based drug and alcohol counsellor assigned to work specifically with older people may help identify misusers, while regular medical audit of substance use could also improve detection and referral rates.

Treatment should be based on a careful assessment and matching of each patient's needs to the range of treatment options available. Detoxification from alcohol may be indicated for some patients; others may need weaning off benzodiazepines, which may take weeks or months to achieve. Emphasis should be placed on non-drinking social activities in the context of the person's circumstances and social support networks. Individual counselling may be helpful for some elderly misusers, with a supportive and less confrontational approach to treatment, or referral to Alcoholics Anonymous. Disulfiram should be used cautiously, under supervision, and only short term since there is a risk of precipitating a confusional state.

Treatment specifically designed for elderly people may be more beneficial than programmes for mixed ages: older people frequently have concomitant medical and psychiatric illnesses and place heavier demands on health services. The most effective treatment may be that given through facilities that specifically serve elderly people.

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Policy on drug misuse in Europe

New monitoring centre should provide opportunity for more soundly based policy

Policies for managing drug misuse among the countries of Europe are characterised by unprincipled variations[1] and a dearth of information or analysis that would support systematic decision making. For the past two decades purely political priorities have been the dominant influences in many European nations. The establishment in the European Union of a Monitoring Centre for Drugs and Drug Addiction provides an important opportunity to change this climate so that future management of drug misuse is properly informed by science.

The current lack of information and analysis shows itself in several ways. Radical and interesting changes in policy, such as the removal of criminal sanctions for personal possession of psychoactive drugs in Italy and Spain, have gone unevaluated.[2] Few European nations conduct national surveys that would provide the basis for systematic estimates of the prevalence of drug misuse. In the case of France and Italy it has not been possible to identify survey data on drug misuse even at the city or regional level.[2] Moreover, in most countries the data that have been collected have remained almost unanalysed beyond official descriptive reports, themselves often buried in obscure publications. Rarely if ever have files been made available for secondary analysis by other scholars. In some nations estimates of the numbers of people dependent on illicit drugs have the precision of medieval estimates of the angel carrying capacity of pinheads. For Britain figures as diverse as 25 000 and 250 000 opiate addicts have been cited, and for Italy figures of 100 000 and 300 000 heroin addicts are equally plausible and equally unfounded.

Unsurprisingly, treatment also varies enormously, with scarcely any reference to a base of research and analysis. In Britain, the United States, and the Netherlands methadone is accepted as the centrepiece of treatment for opiate addicts on the basis of a substantial number of reports of reasonable (though not excellent) quality on the effectiveness of such treatment.[3] In some other European nations it is scarcely available at all.[4] Greece bans most opiate substitute treatment. France has a total of 52 patients receiving methadone, and Germany had fewer than 1000 patients taking methadone before 1992. In Spain and Britain the availability of substitute treatment varies greatly among regions, and in Italy methadone is mostly limited to short term prescription.[4]

The continued concern about the prevalence of HIV infection among intravenous drug users is leading to sharp changes in practice, which are not necessarily based on research or evaluation. Thus Germany has developed treatment facilities for 8000 people in the past two years, while French policy makers (after a decade of denial[5]) and health professionals are finally pushing for a major expansion in the availability of opiate substitute treatment. Pockets of opposing views remain—for example, in Norway and Sweden—but overall there seems to be a swing in favour of prescribing substitutes. On the basis of the available scientific evidence, the United Kingdom Advisory Council on the Misuse of Drugs has recently strongly endorsed the role of structured maintenance treatment with oral methadone in preventing HIV infection.[6] Unfortunately, earlier experiences suggest that rapid reactive shifts in attitude may be short lived and not soundly based. The recent Italian laws restricting the consumption of methadone to the confines of treatment centres are an example of reactive decision making inappropriately responding to the problem of methadone diversion.

Different models of mental illness and addiction across Europe also contribute to these sharply divergent responses,[7] as do differing systems of health and welfare provision. But the longstanding rejection of methadone in so many countries is symptomatic of the moralism that has characterised drug policy for so long and that makes analysis and research such marginal activities.

The establishment of the European Monitoring Centre for Drugs and Drug Addiction in Portugal during 1994 not only represents a step toward addressing the information and policy gap; it may also provide a battleground for airing