Fingerhood (Dec. 13 issue) 1 point out the high rates of substance-use disorders among older adults, with alcohol-use disorders being the most prevalent type. The creation of new models of care for older adults as advocated by the authors has to be reinforced by considering cognitive disorders related to age and substance use. More than two thirds of patients with alcohol-use disorder have cognitive impairments, leading to a more severe course, including more relapses, poor adherence to treatment, and more hospital admissions, than occurs in patients with alcohol-use disorders without cognitive impairments. 2 In addition, the National Epidemiologic Survey on Alcohol and Related Conditions showed that patients with substance-use disorders are more likely than persons without such disorders to have psychiatric disorders, which are associated with cognitive disorders. 3 Thiamine deficiency, malnutrition, and benzodiazepine treatments, which are common in patients with substance-use disorder, worsen cognitive functions. Symptoms of substance-use disorders could be mistaken for dementia or other forms of cognitive impairment. 4 Clinicians are able to assess cognitive disorders in older adults with substance-use disorder by means of tools such as the Montreal Cognitive Assessment or the Brief Evaluation of Alcohol-Related Neuropsychological Impairments. 5 Thiamine supplementation is an important part of treatment in older patients with alcohol-use disorder.

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DOI: 10.1056/NEJMci1900712

TO THE EDITOR: We would like to contribute some additional information regarding substance-use disorders. First, long-term use of alcohol accelerates the functioning of liver enzymes, such as cytochrome P-450, especially the subfamily 2E1 (CYP2E1). Such activation may interfere with drug metabolism. Some studies have shown that the elderly take, on average, seven medications per day. Therefore, drug interactions with alcohol can change the effectiveness of medications. 1

Mickaël Naassila, Ph.D.
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Second, although the elderly can metabolize and eliminate alcohol with the same efficiency as younger people, they are at higher risk for intoxication and adverse effects. The probable reason is that in older persons, a higher concentration of alcohol in the blood is reached after they consume an equal amount of alcohol as younger persons, since the elderly have less body water and the alcohol becomes more concentrated.

Finally, in the elderly there is less ability to produce tolerance to the effects of alcohol. Even if the elderly drink the same amount of alcohol over time, there is no decrease in the negative effects. Studies in laboratory animals have confirmed this hypothesis.

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THE AUTHORS REPLY: We agree with Angerville et al. that comprehensive assessment of the older patient ought to include a cognitive evaluation to screen for cognitive impairment and coexisting cognitive disorder. They are right to point out that an unrecognized coexisting cognitive disorder can worsen the clinical course and treatment for substance-use disorder, as it can for other medical conditions. We agree that thiamine supplementation is appropriate in older patients with alcohol-use disorder, as it is in younger patients.

Galduróz and Tomita reinforce our message that physiologic and pharmacokinetic changes associated with aging can lead to increased sensitivity to the harmful effects of alcohol at lower levels of consumption. They highlight an important point of our article, that older adults are more likely to be taking multiple prescription medications that can interact with alcohol and other substances and that can increase the risk of adverse consequences. We agree that heightened awareness of these factors is essential for all clinicians caring for older adults.

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Since publication of their article, the authors report no further potential conflict of interest.

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