THE AGEING DRUG USER

R. Robertson, Edinburgh Drug Addiction Study, Muirhouse, Edinburgh

In recent years, most physicians and primary care medical practitioners have encountered clinical situations involving illegal drug use. As in most other clinical areas, issues related to such addiction appear to become increasingly complex, more medical specialties are involved and treatment options and requirements proliferate. Many drug injecting patients formerly conformed to a convenient stereotype, but all this is changing. Not only is the range of drugs being used increasing, but the range of treatments and interventions which may be required and are available are also increasing. The requirements of drug users as they age have to be addressed specifically and the likely demands of such addicts are opening up new areas of medical practice.

INTRODUCTION

Europe and North America have been associated with almost four decades of injecting drug use, about which numerous medical publications have appeared. These record epidemics, clinical clusters and individual case problems usually related to infections consequent from injecting and the serious toxic side-effects produced by the pharmacological properties of the drug injected. It is perhaps surprising that a mortality of 1–2% per annum[1, 2] was recorded in most cohorts reported, which seems quite low in the light of such damaging behaviour. Injected substances are frequently adulterated drugs of unknown quantity and quality mixed with non-sterile solvents (tap water, toilet water or worse) which are administered through usually non-sterile injecting equipment which is often shared directly or indirectly with one, or perhaps many, other individuals. From amongst the early starters involved in such a drug culture from the 1960s, a number are now in their fifth, sixth or even later decade. The 'baby boomers' of the drug scene from the mid- to late-1970s are now in their late thirties to mid forties, a large percentage have children and many are also grandparents. The children of long-term drug users are now being investigated,[3] with obstetricians increasingly reporting findings.[4, 5]

NATURAL HISTORY OF DRUG DEPENDENCE

The natural history of drug dependence is associated with a 'J' shaped curve of mortality; the majority of those who die are in the younger age group, but another peak shows up in later years. The majority of such habitual drug users frequently become invisible after their early years of being all too visible to the medical and criminal justice systems. These users should now be considered seriously as they approach the second peak in the mortality curve, a peak often associated with suicide but also containing many other causes of death, including death at a relatively young age from degenerative diseases which have set in prematurely.

As with drug users from the younger age group, older habitual drug users show a variation in their addictive features. There are well documented and reported accounts of patients who continue to inject into their fifties and sixties whilst otherwise leading a normal and productive life with few or no encounters with the law. A second group of intravenous drug addicts shift their addiction problem into the sphere of alcohol misuse. A third group become drug free, maybe for many years. However, it has to be borne in mind that increasingly there is a significant group of middle aged drug addicts who continue to inject drugs, or to suffer from the consequences of past drug injecting. As this group of patients develops the diseases associated with late middle age to early old age such as osteoarthritis, ischaemic heart disease and diabetes mellitus, it is likely that they will require medication with many drugs, including analgesics. Similarly, if these patients develop cancer, past or current opiate abuse problems would have to be considered in their treatment. Those looking after such patients would require information about their past, or any ongoing use of addictive drugs because some patients are likely to encounter difficulties with renewed addiction while others, because of their past experience, may be reluctant to use opiates in a conventional way, or even at all. An ongoing maintenance treatment with methadone or self-medication may make pain control complex and difficult in those who require it.

DELAYED COMPLICATIONS OF INJECTING DRUG USE

Inevitably, the legacy of past infection with blood borne viruses will become increasingly common as the addicts reach middle age. Chronic Hepatitis C infection might present with liver failure and cirrhosis and such complications as cirrhosis-associated bacterial peritonitis, decompensating liver or hepato cellular carcinoma function. Undiagnosed HIV infection should always be considered in the differential diagnosis in this age group, particularly when neurological complaints which do not follow easily recognisable patterns are found.

From the poor estimates which exist of national prevalence figures, more than 500,000 individuals who have had experience of injecting drugs over the last few decades are living in the community.[6] A large percentage of these have chronic Hepatitis C infection,[7] as compared with the published estimates of Hepatitis C virus (HCV) prevalence in the general population: 0·7% in the UK (400,000 individuals) and 1·8% in the US (3·6 million individuals).[8, 9] Many of them have incipient bronchitis and chronic bronchitis and all of them will also develop degenerative conditions in keeping with the rest of the population. Bronchogenic carcinoma is likely to figure prominently in a group who may have smoked tobacco and cannabis heavily from an early age.

Clinical guidelines in the treatment of opiate-dependent patients highlight the roles of the family doctor in primary care and drug specialist in prescribing methadone. Most illustrations used in this context include young or very

young individuals injecting in depressing circumstances.[10] Whilst this may be the stereotype that is suggested, the reality is changing with the increasing longevity of the population. One of the best known drug users ever, William Burrows, died at the age of 78, and in his latter years, looked (at least in those photographs available to those not close to him) to be a reasonably fit elderly man.[11]

MATURITY BRINGS EXPERIENCE AND POSSIBLY RESPONSIBILITY

This group of older chronic mainlining addicts deserves our best attention. These patients should be handled with respect and dignity as they have acquired significant medical information, albeit sometimes obtained unconventionally, and can very quickly assess whether medical personnel with whom they come into clinical contact are interested and sympathetic, or are likely to be unhelpful due to unnecessary prejudice or lack of insight. These patients may prove troublesome for physicians, surgeons and geriatricians not used to demanding or assertive patients who have acquired and profess an alternative view on treatments, especially pharmacological interventions. In the clinical context, zero tolerance of drug users may well be an attitude of the past.

Consideration should now be given to the reasons behind poor compliance with therapies, non-attendance at clinics and irrational decisions by some of these patients. It may be that therapies, particularly in terms of analgesics and sedation, are inadequate, and set appointments hard to keep for an impoverished group. Decisions taken by patients can seem irrational to health care workers with little understanding of the life problems facing drug users. Confidentiality is a right and should always be considered important, although with drug users it is sometimes poorly respected. Ethical problems relating to the health of partners and dependent children may be expected and sometimes dilemmas have to be faced and solved.

Throughout the last ten or 15 years an awareness of drug users has increased in many specialties and hospital departments, but treating a chronic older drug addict may be considered as being a novelty outwith their competency and, at times, their interest. Genitourinary medicine specialists had to reinvent themselves as AIDS specialists in the 1980s, infectious diseases consultants took on the challenge of HIV infection and gastroenterologists and liver specialists had to adjust to the consequences of the HCV infections of the 1990s. Cardiologists and surgeons struggle unenthusiastically with the multidimensional nature of drug dependency and it seems doubtful that geriatricians are prepared for them. Various sources have suggested setting up a Royal Commission to consider the various aspects of drug use, and this may be a useful suggestion. Such a commission should certainly investigate and address the need for a substantial increase in medical undergraduate education and postgraduate clinical medical understanding of drug dependency. Drug dependency is no longer the province of psychiatry and the time has come for part of it to involve the geriatricians.

RESEARCH AGENDA

The opportunities for research activity in this emerging field are extensive. Important questions have already been addressed in HIV circles – risk factors for heterosexual transmission, molecular epidemiology patterns and collaborations with virology provide information for vaccine and drug trials. Similar collaborations on HCV infections are underway. New research into the ageing drug user and clinical patterns of disease in this group is much needed – every speciality is likely to have a research agenda.

Choices of treatments for chronic addicts will, and should, expand in the next few years. A long and current obsession with the single strand of maintenance treatment, methadone, may well require a change to a choice of drug therapies to suit different recipients. Similarly, a choice of places where treatment is offered is inevitable. The traditional psychiatric clinic is giving way to community care in the UK and Europe, and pressure is mounting in the US for the same thing to happen. Alternative treatments are being studied; for example, extensive research in Europe and North America has focused on buprenorphine as an alternative to methadone. Clinical trials in Switzerland, London and Vienna are focusing on medically pure diamorphine injection as a substitute, and morphine latterly as an alternative oral medication. This sort of psychotherapeutic research is likely to add substantially to the treatment options – and, regrettably, modifications in treatment are likely to result in treatment complications. Similar research in other areas is already transforming the literature relating to drug users from one of epidemiological, behavioural and psychological focus to one of clinical medical experience, biomedical insights and a new genetic and molecular understanding of the basis of addictions and the effects of long-term drug use.

Clinicians should be aware of these new developments and the opportunities for inclusion of a knowledge of drug dependency in their own specialties. An inevitable normalisation of drug taking in society and the increasing experiences of people in their middle years of drug taking in the past is likely to change all our attitudes and to require a less judgemental and a more interventionist approach.

REFERENCES

1. Hser YI, Anglin D, Powers K. A twenty-four year follow-up of Californian narcotic addicts. *Arch Gen Psychiatry* 1993; **50:**577-84.
2. The Advisory Council on the Misuse of Drugs. *Reducing drug related deaths*. London: Stationery Office; 2000.
3. Suchman NE, Luthar FS. Maternal addiction, child maladjustment and socio-demographic risks: implications for parenting behaviour. *Addiction* 2000; **95:**1417-28.
4. Fischer G. Treatment of opioid dependence in pregnant women. *Addiction* 2000; **95(8):**1141-4.
5. Johnstone FD. Pregnant drug users. In: Robertson JR, editor. *Management of drug users in the community*. London: Arnold; 1998.
6. Corkery JM. Statistics of drug addicts notified to the Home Office, United Kingdom, 1996. Home Office Statistical Bulletin. London: Home Office; 1997.
7. MacDonald MA, Wodak AD, Dolan KA *et al.* Hepatitis C virus antibody prevalence among injecting drug users at selected needle and syringe programs in Australia, 1995–1997. *Med J Aust* 2000; **172:**57-61.
8. Sallie R, King R, Silva E *et al.* Community prevalence of hepatitis C viraemia: a polymerase chain reaction study. *J Med Virol* 1994; **43:**111-4.
9. Alter MJ, Kruszon-Moran D, Nainan OV *et al.* The prevalence of Hepatitis C virus infection in the United States 1988 through 1994. *N Engl J Med* 1999; **341:**556-62.
10. New British guidelines on the clinical management of drug misuse and drug dependence. *Addiction* 2000; **95(3):**325-6.
11. Miles B. *William Burrows: El Hombre Invisible*. London: Virgin; 1992.