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Consensus validation of the POSAMINO (POtentially Serious Alcohol–Medication INteractions in Older adults) criteria

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ABSTRACT

Objectives Older adults are particularly vulnerable to adverse effects from concurrent alcohol and medication use. However, there is limited evidence regarding the prevalence of these adverse outcomes among older adults, and there is a lack of consensus regarding what constitutes an alcohol-interactive medicine. The objective of this study was to develop an explicit list of potentially serious alcohol–medication interactions for use in older adults.

Design Following a systematic review, review of drug compendia and clinical guidance documents, a two-round Delphi consensus method was conducted.

Setting Ireland and the United Kingdom (UK), primary care and hospital setting.

Participants The Project Steering Group developed a list of potentially serious alcohol–medication interactions. The Delphi panel consisted of 19 healthcare professionals (general practitioners, geriatricians, hospital and community pharmacists, clinical pharmacologists and pharmacists, and physicians specialising in substance misuse).

Results An inventory of 52 potentially serious alcohol–medication interactions was developed by the Project Steering Group. British National Formulary black dot warnings (n=8) were included in the final criteria as they represent 'potentially serious' interactions. The remaining 44 criteria underwent a two-round Delphi process. In the first round, 13 criteria were accepted into the POtentially Serious Alcohol–Medication INteractions in Older adults (POSAMINO) criteria. Consensus was not reached on the remaining 31 criteria; 9 were removed and 8 additional criteria were included following a review of panellist comments. The remaining 30 criteria went to round 2, with 17 criteria reaching consensus, providing a final list of 38 potentially serious alcohol–medication interactions: central nervous system (n=15), cardiovascular system (n=9), endocrine system (n=5), musculoskeletal system (n=3), infections (n=3), malignant disease and immunosuppression (n=2), and respiratory system (n=1).

Conclusions POSAMINO is the first set of explicit potentially serious alcohol–medication interactions for use in older adults. Following future validation studies, these criteria may allow for the risk stratification of older adults at the point of prescribing.

Strengths and limitations of this study

- ► The POtentially Serious Alcohol–Medication INteractions in Older adults criteria were developed in a robust fashion, using a two-step process involving a systematic review and two-round Delphi process.
- ► The Delphi consensus technique used in this study is flexible and enabled communication from a diverse group of healthcare professionals from both the UK and Ireland.
- ► The final criteria will need to be further validated prospectively to quantify the magnitude of risk posed for each criterion for adverse outcomes in older adults.
- ► Once validated, these criteria have the potential to inform medical decision making and enable healthcare professionals to risk stratify older adults at the point of prescribing and prioritise alcohol screening and brief interventions in high-risk groups.

BACKGROUND

Population demographics are changing globally, with the proportion and age of the older population continuing to increase.[1] While alcohol consumption tends to decline with age, older adults are inclined to drink more frequently.[2] Ageing is associated with a variety of physiological changes, which may place older adults at an increased risk of alcohol-related health problems.[3 4] In fact, compared with younger adults, they encounter a disproportionate burden of alcohol-related harm, with reported alcohol-related deaths highest among those aged 55 to 74 years in England in 2010.[4]

Polypharmacy is also increasing in older adults[5] and certain medicines may interact with alcohol, increasing the risk of adverse events such as sedation, hypotension, gastrointestinal bleeds, hypoglycaemia and liver damage.[6 7] In a previous observational study, moderate alcohol consumption increased the risk of adverse drug reactions by 24% among older adults.[8] Alcohol interactive (AI) medicines may interact with alcohol by altering the effects (pharmacodynamic) or

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metabolism (pharmacokinetic) of the medication and/or alcohol.[7] The interactions may occur with any alcohol or may follow a dose response, with the severity and risk of interactions increasing with increasing levels of alcohol consumption.[6]

While a number of studies have investigated the concurrent use of alcohol and AI medicines among older adults,[9] there is still a lack of agreement regarding the inclusion of AI medicines across studies. Several studies have reported on a broad range of medication classes, using different drug reference sources and software to identify medications as AI, thus leading to a lack of consistency in the inclusion of these medicines.[9] Other studies focused on psychotropic medications alone.[9]

Despite the findings of our previous systematic review, highlighting a high prevalence of concurrent use among older adults, no study to date has examined longitudinal associations of concurrent use with adverse outcomes.[9] An evidence-based list of potentially serious alcohol–medicine interactions for older adults has potential in a clinical setting, once validated, allowing for the identification of older adults whose alcohol consumption places them at increased risk and who would benefit from a preventative intervention. Therefore, the aim of this study is to derive the first set of explicit potentially serious alcohol–medication interactions in older adults.

METHODS

Study design

A Delphi consensus technique was used to develop the list of potentially serious alcohol–medication interactions in older adults. The Delphi method allows a consensus opinion to be reached among a panel of experts through an iterative process of questionnaires.[10] Ethics approval for this study was obtained from the Royal College of Surgeons in Ireland (RCSI) (reference number REC 1097). A Project Steering Group comprising academic and clinical pharmacists, a general practitioner and an epidemiologist (authors) from the RCSI School of Pharmacy and Health Research Board Primary Care Centre was formed to develop the initial list of potentially serious alcohol–medication interactions and to later oversee the Delphi consensus study.

Compilation of initial list of potentially serious alcohol–medication interactions

Following a comprehensive systematic search using MEDLINE (PubMed), Embase, Scopus and Web of Science databases,[9] an extensive list of medications with potential to interact with alcohol was identified by the Project Steering Group. A combination of the following keywords and MeSH terms were used: 'ethanol', 'alcohol', 'drug interactions', 'drug alcohol interaction' and 'aged'. This search was supplemented by a search in Google Scholar and by hand searching references of retrieved articles. The search was restricted to English-language articles and articles published since January 1990. Furthermore, the British National Formulary (BNF), Stockley's Drug Interactions and Martindale Complete Drug Reference drug compendia were also searched.[11–13] Additional documents such as clinical guidance documents[14] and previous reviews[6 7] were also accessed. Information extracted included medication name/class, potential adverse outcome(s), whether an interaction is likely to occur with any alcohol consumption or with heavy consumption using national low risk drinking guidelines[15 16] and, if reported, evidence supporting the interaction. The list of medications was organised according to the BNF physiological classification system. There was considerable heterogeneity across reference sources in terms of identifying medications as having potential to interact with alcohol, with no age-specific information for interactions. Furthermore, there were inconsistencies in relation to the quantity of concurrent alcohol consumption that should be avoided. For example, the Martindale mentioned that alcohol combined with non-steroidal anti-inflammatory drugs (NSAIDs) may increase the risk of gastrointestinal bleeds with no mention of alcohol consumption patterns, Stockley's described that both NSAIDs and excessive alcohol use carry the risk of gastrointestinal adverse effects, while NSAIDs and alcohol were not included as an interaction in the BNF. For the next step, the Project Steering Group reviewed and assessed each medication or drug class. Using the definition of 'necessary to avoid' previously described by Dreischulte *et al*,[17] it was considered necessary to avoid concurrent alcohol with a specific medication if, in an average older adult, concurrent use of alcohol with this medication would be considered unsafe because (a) there is sufficient evidence that the patient is likely to be harmed and (b) the likely harm to the patient is large enough to be clinically significant.

Drugs were excluded for the following reasons: their interaction with alcohol was not considered serious, that is, unlikely to cause significant harm to the patient (eg, selective serotonin reuptake inhibitors and alcohol)[13]; the medication is not licensed for use in older adults; the medication is only administered in a hospital environment (eg, trabectedin); and interaction with alcohol may only occur during alcohol withdrawal or has been withdrawn from the market in the UK or Ireland. Following these exclusions, a truncated list was further reviewed by the Project Steering Group by a consensus discussion. In this process, the Project Steering Group agreed that BNF black dot warnings would be included in the final list. BNF black dots refer to potentially serious drug–alcohol interactions where concurrent use should be avoided or only undertaken with caution and appropriate management. In the paper version of the BNF, these potentially serious drug–alcohol interactions are highlighted to prescribers by flagging them with a 'black dot'.[11] Furthermore, the amount of alcohol to be avoided with each medication class was defined through group discussion, based on both the evidence available and the members' own clinical experience. Additionally, it was agreed that the following

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adverse outcomes associated with concurrent use were defined using clinical guidance documents and reviews to ensure clarity among all participants: orthostatic hypotension,[18] hypoglycaemia[19] and lactic acidosis.[20]

Selection of the Delphi panel

A total of 51 experts from Ireland and the UK were invited (via email or letter) to participate as part of the Delphi consensus panel. The experts invited to participate on the Delphi consensus panel were peer recognised by the Project Steering Group or nominated by other panel members on the basis of their clinical experience or knowledge of alcohol–medication interactions or care of older persons.

Reasons for non-participation were not required; however, in some instances they were provided, which included time commitments and lack of clinical knowledge of alcohol–medication interactions. In total, 19 participants (37%) agreed to participate and written consent was received from all participants before the study. The panel consisted of general practitioners (GPs) (n=5), geriatricians (n=3), hospital pharmacists with expertise in care of older adults (n=3), community pharmacists (n=3), clinical pharmacologists (n=2), clinical pharmacists specialising in substance misuse (n=2) and a physician specialising in substance misuse (n=1). Panel members were not provided with compensation for participation.

The Delphi validation technique and process

An online questionnaire was piloted by two pharmacists and two GPs, to identify any potential problems and to approximate the completion time for the survey. Following amendments, the 19 participants were sent a link to the online POtentially Serious Alcohol–Medication INteractions in Older adults (POSAMINO) questionnaire (via SurveyGizmo) in March 2016. Participants were given 4 weeks to complete the online questionnaire and all participants were sent a reminder email after 2 weeks to encourage participation. The questionnaire was both anonymous and confidential.

The quantity of alcohol per standard drink (SD) (10 g alcohol in Ireland) or unit (8 g alcohol in the UK) was defined at the beginning of the survey. As some interactions are listed with any alcohol consumption and others with 'heavy' consumption, we provided definitions of both at the beginning of the questionnaire. Any alcohol consumption was defined as ≥1 SD of alcohol in Ireland or ≥1 unit of alcohol in the UK, with heavy consumption defined according to Irish and UK national low risk drinking guidelines.[15 16] The panel were instructed to evaluate each potential interaction listed according to the 'necessary to avoid' framework described above.[17] Medications were categorised according to the BNF physiological classification system. Each statement was presented in the same format stating: It is necessary to avoid (quantity of alcohol) (any or heavy) with (medications/drug class), followed by a brief rationale for the statement. For example: *It is necessary to avoid: Any alcohol consumption with first-generation antihistamines (for example promethazine). (Rationale: Concurrent alcohol consumption with first-generation antihistamines can increase the risk of sedation).*

Participants were asked to rate their agreement with each statement, using a five-point Likert scale (1=strongly disagree to 5=strongly agree), along with any additional comments or suggestions for additional medicines to be included.

After each round, the median and IQRs were calculated for each statement. Consistent with previous Delphi consensus studies, the consensus level required for a statement to be retained was defined a priori as a median of 4 or 5 with a lower quartile value of ≥4.[21] If a statement had an upper quartile value of ≤2, this indicated there was general disagreement with the statement between panel members, and the statement was rejected. If group consensus was not reached, the criteria were reviewed by the Project Steering Group and were removed based on comments or revised and included in the second questionnaire. In the second questionnaire, panellists were provided with links to the most recent evidence relating to each of the alcohol–medication interactions, to help facilitate their decisions due to uncertainty in round 1. As with round 1, the median response and IQR were calculated and evaluated by the Project Steering Group using the same thresholds to determine consensus between the panel members. If consensus was not reached following the second round, the statement was rejected. Statistical analysis was performed using STATA V.13 and Microsoft Excel 2010.

RESULTS

Following an initial review of the literature, Anatomical Therapeutic Chemical codes for a total of 364 AI medicines were extracted by the Project Steering Group (online supplementary file 1). Medicines were classified according to drug classes and organised according to BNF physiological classification systems. From this list, a total of 63 statements were initially compiled based on the 'necessary to avoid' framework.[17] Following group discussions, 11 statements were removed/updated or merged together, based on the steering group's clinical knowledge or experience with medicines. For example, the steering group decided to no longer classify benzodiazepines according to the duration of action, as both long acting and short acting have the potential to interact with alcohol. Furthermore, a total of eight BNF black dot warnings were included in the final criteria as they represent potentially serious interactions.

All 19 panel members completed the round 1 questionnaire in which 44 statements were presented. Consensus was reached on 13 statements, with no statements rejected (table 1). Thirty-one statements were reviewed by the steering group, with nine statements removed based on comments from the panel, if the interaction was not relevant to older adults or the interaction was not of clinical

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Table 1 Results from the two-round Delphi process

		Round 1					Round 2					
Physiological system	**Potentially serious interactions as listed in the BNF**	**Total**	**Accept**	**Revise**	**Reject**	**Removal**	**New statements included**	**Total**	**Accept**	**Revise**	**Reject**	**Final criteria**
Cardiovascular system	1	14	1	13	0	3	2	12	7	0	5	9
Respiratory system	0	1	1	0	0	0	0	0	0	0	0	1
Central nervous system	4	12	6	6	0	1	5	10	5	0	5	15
Infections	2	5	0	5	0	3	0	2	1	0	1	3
Endocrine system	0	5	3	2	0	0	0	2	2	0	0	5
Obstetrics, gynaecology and urinary tract disorders	0	2	0	2	0	1	1	2	0	0	2	0
Malignant disease and immunosuppression	1	1	0	1	0	0	0	1	1	0	0	2
Nutrition and blood	0	1	0	1	0	1	0	0	0	0	0	0
Musculoskeletal system	0	3	2	1	0	0	0	1	1	0	0	3
Total	8	44	13	31	0	9	8	30	17	0	13	38

BNF, British National Formulary

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significance, for example, heavy alcohol consumption with vitamin A preparations. Furthermore, eight new statements were included in round 2 based on comments from panellists at the first round.

A total of 18 out of the 19 recruited participants completed the round 2 questionnaire. Of the 30 statements included in the second questionnaire, consensus was reached for 17 statements. The remaining 13 statements were rejected as no consensus was reached. In total, consensus was reached for 30 potentially serious drug–alcohol interactions in older adults, and with the inclusion of BNF black dot warnings, the final list was 38 statements.

This final 38-item POSAMINO criteria (see box 1) were organised over the following physiological systems: central nervous system (n=15), cardiovascular system (n=9), endocrine system (n=5), musculoskeletal system (n=3), infections (n=3), malignant disease and immunosuppression (n=2) and respiratory system (n=1).

DISCUSSION

Principal findings in relation to previous studies

While older adults experience a disproportionate burden of alcohol-related harm,[4] research suggests that healthcare professionals are less likely to discuss alcohol consumption with older adults.[22 23] Flagging older adults at the point of prescribing an AI medication may facilitate targeted screening and interventions to help reduce harm. Despite the high propensity for alcohol–medication interactions among community-dwelling older adults, our recent systematic review has highlighted that there is still a lack of consensus regarding what constitutes an AI medication.[9] This study reports the development of a set of 38 explicit criteria, POSAMINO, for identifying older adults at risk of potentially serious alcohol–medication interactions.

The final POSAMINO criteria consist of seven different drug classes, with central nervous system (CNS) medicines representing 40% of the criteria. Estimates from our previous study indicate that approximately one in five older Irish adults are exposed to CNS agents, with over half of patients using CNS agents also reporting concurrent alcohol consumption.[24] Nine of the final 38 criteria concern cardiovascular agents, another widely used drug class among aged adults.[24] There is also a high risk of adverse effects associated with these agents, with antiplatelets, diuretics and anticoagulants identified as the most common drug classes involved in preventable drug-related admissions, in a previous study.[25] Analgesics such as non-steroidal anti-inflammatory drugs (NSAIDs), opioids, paracetamol and gabapentin (used for neuropathic pain) were also included in the final POSAMINO criteria. The prevalence of chronic pain increases with age and older adults may consume alcohol to help cope and manage their pain.[26] This behaviour may also predispose older adults to adverse outcomes associated with concurrent use with analgesics (for example increased sedation, falls and gastrointestinal bleeds).

The development of the POSAMINO criteria is important for several reasons. In the absence of an explicit list of AI medications, multiple drug reference sources have been used in previous studies leading to a lack of consistency in the inclusion of medications across studies,[24 27–30] which may result in biased estimates of potential risk among older adults. Furthermore, some of these interactions may be theoretical with trivial clinical significance. Therefore, this study developed a consensus-based set of explicit criteria for potentially serious alcohol–medication interactions in older adults rather than an exhaustive list of medications with potential to interact with alcohol. Consistent with existing literature, the POSAMINO criteria classify CNS agents as AI medications with the potential to cause serious harm to older adults.[8 24 27–41] However, some of the previous studies focused on sedatives/hypnotics only.[33 39 41] We identified a number of additional CNS agents, such as anti-Parkinson's drugs (eg, pramipexole, apomorphine and levodopa), which may be overlooked if we focus solely on sedatives or hypnotics.

Furthermore, the POSAMINO criteria also includes a wide range of other drug classes, such as cardiovascular, respiratory system, musculoskeletal, malignant disease, infections or endocrine agents that were not all considered among previous studies.[8 27 28 30–32 35] It is also important to note that there has been little emphasis on the adverse outcomes or severity of these potential interactions.[9 29] The development of the POSAMINO criteria may help identify older adults at risk of potentially serious alcohol–medicine interactions in the future.

Clinical implications and future research

This study adds to a growing body of research investigating the concurrent use of alcohol and AI medicines in older adults. Undoubtedly, adverse drug events (ADEs) represent a major burden on healthcare, with ADEs detected in 26.3% of patients aged ≥65 years admitted to an Irish hospital with acute illnesses.[42] The increasing use of multiple medications,[5] combined with an increased frequency of alcohol consumption[2] and age-related physiological changes, may predispose older adults to these adverse events. The significant burden of alcohol-related harm and mortality among older adults[4] indicates a pressing need for future interventions to minimise risk. However, prior to informing clinical or public health initiatives, the final criteria developed from this study will require further validation to prospectively quantify the magnitude of risk posed for each criterion for adverse outcomes in older adults. In particular, the quantity of alcohol specified in each criterion will need to be further evaluated in prospective studies. Once validated, these criteria have the potential to inform medical decision making and enable healthcare professionals to risk stratify older adults at the point of prescribing and prioritise alcohol screening and brief interventions in high-risk groups. This is essential, as older people have previously reported little knowledge

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Box 1 Final POtentially Serious Alcohol–Medication INteractions in Older adults criteria (n=38)

Cardiovascular system

1. Heavy alcohol consumption with multiple antihypertensive combinations
Rationale: Concurrent use of alcohol consumption and antihypertensives may increase the risk of orthostatic hypotension.
2. Heavy alcohol consumption with warfarin (and phenindione)
Rationale: Heavy episodic alcohol consumption is associated with an increased risk of major bleeds.
3. Heavy alcohol consumption with regular use of low-dose aspirin (75 mg)
Rationale: Heavy alcohol consumption combined with aspirin may cause a small increase in gastrointestinal blood loss.
4. Heavy alcohol consumption with both regular and as required nitrates (eg, glyceryl trinitrate, isosorbide dinitrate and isosorbide mononitrate)
Rationale: The combined haemodynamic effects of alcohol and nitrates may increase the risk of exaggerated hypotension.
5. Heavy alcohol consumption with the vasodilatory medication nicorandil
Rationale: The combined haemodynamic effects of alcohol and nicorandil may increase the risk of exaggerated hypotension.
6. Heavy alcohol consumption with the combined use of both nitrates and vasodilator medication (eg, nicorandil)
Rationale: The combined haemodynamic effects of alcohol with nitrates and vasodilator drugs may increase the risk of exaggerated hypotension.
7. Heavy alcohol consumption with diuretics (eg, loop diuretics (furosemide), thiazide diuretics (bendroflumethiazide) and potassium-sparing diuretics (amiloride))
Rationale: The concurrent use of alcohol and antihypertensives may increase the risk of orthostatic hypotension.
8. Heavy alcohol consumption with alpha blockers (eg, terazosin)
Rationale: The concurrent use of alcohol and antihypertensives may increase the risk of orthostatic hypotension.
9. Heavy alcohol consumption with centrally acting antihypertensives (eg, clonidine or methyldopa)
Rationale: Alcohol consumption combined with centrally acting antihypertensives may increase the risk of sedation and/or orthostatic hypotension.

Respiratory system

1. Any alcohol consumption with first-generation antihistamines (eg, promethazine)
Rationale: Concurrent alcohol consumption with first-generation antihistamines can increase the risk of sedation.

Central nervous system (CNS)

1. Heavy alcohol consumption with benzodiazepines (eg, diazepam) and benzodiazepine-related medications (eg, zopiclone)
Rationale: Alcohol consumption combined with benzodiazepines and benzodiazepine-related medications may enhance CNS depressant effects.
2. Heavy alcohol consumption combined with opioids
Rationale: Alcohol consumption combined with opioids may enhance CNS depressant effects of alcohol.
3. Heavy alcohol consumption with duloxetine
Rationale: Heavy alcohol consumption combined with duloxetine may increase the risk of hepatotoxicity.
4. Heavy alcohol consumption with all antipsychotics
Rationale: Alcohol consumption combined with antipsychotics may increase the risk of sedation.
5. Any alcohol consumption with barbiturates
Rationale: Alcohol consumption combined with barbiturates may increase the risk of sedation.
6. Heavy alcohol consumption with antiepileptic drugs (AEDs)
Rationale: Heavy alcohol consumption can increase the risk of seizures and sedation in patients taking AEDs.
7. Any alcohol consumption with tricyclic antidepressants
Rationale: Alcohol consumption combined with antidepressants may enhance the CNS depressant effects of alcohol.
8. Any alcohol consumption with tetracyclic antidepressants
Rationale: Alcohol consumption combined with antidepressants may enhance the CNS depressant effects of alcohol.
9. Any alcohol consumption with mirtazapine
Rationale: Alcohol consumption combined with antidepressants may enhance the CNS depressant effects of alcohol.
10. Any alcohol consumption with monoamine oxidase inhibitors (MAOIs)
Rationale: A potentially life-threatening hypertensive reaction can develop in patients taking non-selective MAOIs who consume drinks rich in tyramine (eg, wines, beers and non-alcoholic beers)
11. Heavy alcohol consumption with long-term regular paracetamol use (eg, 1 g four times a day)
Rationale: Heavy alcohol consumption may increase the risk of paracetamol hepatotoxicity especially if alcohol intake is abruptly stopped.
12. Heavy alcohol consumption with gabapentin (when used for neuropathic pain)
Rationale: Alcohol combined with medications for neuropathic pain may increase the risk of sedation.
13. Heavy alcohol consumption with pramipexole or amantadine
Rationale: Alcohol combined with pramipexole or amantadine may increase the risk of sedation
14. Heavy alcohol consumption with apomorphine
Rationale: Alcohol combined with apomorphine may increase the risk of orthostatic hypotension.
15. Heavy alcohol consumption with levodopa (alone or in combination with carbidopa)
Rationale:Alcohol combined with levodopa (alone or in combination with carbidopa) may increase the risk of orthostatic hypotension.

Endocrine

1. Heavy alcohol consumption with insulin
Rationale: Alcohol consumption may enhance the hypoglycaemic effect of insulin.

Continued

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Box 1 Continued

2. Heavy alcohol consumption with metformin
Rationale: Heavy alcohol consumption combined with metformin may increase the risk of lactic acidosis.
3. Heavy alcohol consumption with sulphonylureas
Rationale: Alcohol consumption can enhance the hypoglycaemic effects of antidiabetics.
4. Heavy alcohol consumption with meglitinides (eg, nateglinide)
Rationale: Alcohol consumption can enhance the hypoglycaemic effects of antidiabetics.
5. Heavy alcohol consumption with thiazolidinediones (eg, pioglitazone)
Rationale: Alcohol consumption can enhance the hypoglycaemic effects of antidiabetics.

Musculoskeletal and joint diseases

1. Heavy alcohol consumption with any non-steroidal anti-inflammatory drugs (NSAIDs) (including COX-2 inhibitors)
Rationale: Heavy alcohol consumption and NSAID use carry an increased risk of gastrointestinal bleeds.
2. Heavy alcohol consumption combined with methotrexate or leflunomide
Rationale: Heavy alcohol consumption combined with methotrexate or leflunomide may increase the risk of hepatotoxicity.
3. Heavy alcohol consumption with oral muscle relaxants (eg, baclofen)
Rationale: Concurrent alcohol consumption and muscle relaxants can increase the risk of CNS depression.

Malignant disease and immunosuppression

1. Any alcohol consumption with procarbazine
Rationale: A disulfiram-like reaction can occur when alcohol is given with procarbazine.
2. Heavy alcohol consumption with interferon alpha or interferon beta
Rationale: Heavy alcohol consumption combined with interferons may increase the risk of hepatotoxicity and reduce the response to treatment with interferon.

Infections

1. Heavy alcohol consumption with antimycobacterial medications such as isoniazid, pyrazinamide, ethionamide and rifampicin (alone or in combination)
Rationale: Alcohol combined with antimycobacterial medications can increase the risk of hepatotoxicity.
2. Any alcohol consumption with cycloserine
Rationale: Alcohol consumption may increase the risk of seizures in patients taking cycloserine.
3. Any alcohol consumption with metronidazole or tinidazole
Rationale: A disulfiram-like reaction can occur when alcohol is given with metronidazole.

about risks associated with the concurrent use of alcohol and medications.[43]

Strengths and limitations

The criteria were developed in a robust fashion, using a two-step process involving a systematic review and two-round Delphi process. The Delphi technique is flexible and for this study enabled communication from a group of 19 healthcare professionals from both the United Kingdom and Ireland. Eighteen of the 19 participants completed the two rounds, with participants providing numerous comments and suggestions in both rounds. Similar to previous studies, participants remained anonymous and were not provided with feedback following the first round in order to remove the risk of potential bias.[21]

Inevitably, there were limitations to this Delphi study. With all Delphi studies, participants' judgement may be subjective. In order to reduce this potential bias, a diverse group of healthcare professionals with expertise or interest in the care of older adults were selected. With explicit criteria, there is also a need for regular updates and revision due to the availability of more up-to-date information after development.[44] The developed POSAMINO criteria do not apply to older adults diagnosed with an alcohol use disorder, as chronic heavy alcohol consumption can substantially increase the activity of the cytochrome P450 metabolising enzyme CYP2E1.[7] Finally, older adults may also experience chronic illnesses that affect the metabolism of both alcohol and medications. As a result, it is important that healthcare professionals also consider these comorbid diseases when assessing the risk for potential adverse outcomes.[45]

CONCLUSIONS

Using a systematic review and a two-round Delphi consensus method, we have developed the first set of explicit potentially serious alcohol–medication interactions in older adults (POSAMINO) . Following future validation studies, these criteria may allow for the risk stratification of older adults at the point of prescribing, and prioritise alcohol screening and brief alcohol interventions in high-risk groups.

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Contributors AEH, PJG, CR, TF and GC (the Project Steering Group) conceived and designed this study. AEH and GC conducted initial literature search. AEH communicated with Delphi participants. AEH analysed the data after each round. All Project Steering Group members were involved in interpretation of the data. AEH and GC drafted the manuscript. All coauthors revised the manuscript and gave the approval for publication.

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Competing interests None declared.

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