Ethnic Differences in Herb and Vitamin/Mineral Use in the Elderly

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BACKGROUND: Little information exists on herb and vitamin–mineral supplement use in very old people and whether use varies by ethnicity.

OBJECTIVE: To examine the prevalence and predictors of herb and vitamin–mineral supplement use in a triethnic sample of adults aged ≥77 years.

METHODS: In-home interviews in 1997–1998 assessed medications use and sociodemographic and health factors in community-dwelling elderly non-Hispanic white (n = 125), black (n = 112), and Hispanic (n = 128) adults.

RESULTS: Of the 365 subjects (71.5% ≥80 y old, 52.6% female), 172 reported using at least one of the preparations (vitamin–mineral supplements 132, herbs alone 21, both herbs and vitamin–mineral supplements 19). Herbal use varied by ethnicity: 12.8% in non-Hispanic whites, 16.1% in blacks, and 4.7% in Hispanics. The most commonly used herbs were garlic, *Ginkgo biloba*, saw palmetto, and vinegar. Use of vitamin–mineral supplements, alone or combined with herbs, also varied by ethnicity: 54.4% in non-Hispanic whites, 31.3% in blacks, and 37.5% in Hispanics. In the fully adjusted multivariate model with white ethnicity as reference, the odds ratio of vitamin–mineral supplements use for blacks was 0.37 (95% CI 0.21 to 0.65) and for Hispanics was 0.56 (95% CI 0.30 to 1.03). In bivariate analyses, female gender, black ethnicity, being born in the US, and having coronary artery disease were significantly associated with herbal use ($p < 0.05$); however, in the fully adjusted multivariate model, only the female gender remained significantly associated with herbal use (OR 2.14; 95% CI 1.00 to 4.59).

CONCLUSIONS: Use of herbs or vitamin–mineral supplements is common in very old people and varies by ethnicity.

KEY WORDS: elderly, ethnicity, herbs, minerals, vitamins.

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Use of complementary and alternative medicine (CAM) is growing. The prevalence of CAM use ranges between 30% and 68% of US adults, yet most people do not report this practice to their physicians.[1-8] The physicians, in turn, rarely ask patients about the use of CAM therapies, of which there are at least 27 types including acupuncture, biofeedback, osteopathy, prayer, herbs, vitamin–mineral supplements, and others.[2,3,5] For the elderly, who may be taking several drugs for coexisting multiple diseases, this "don't-ask-don't-tell" approach can mask potential health benefits of alternative medicine use and provide suboptimal monitoring for potential adverse effects.[9,10] Nondisclosure of CAM use is even more perilous in very old people (aged ≥80 y), a population with pronounced age-related decline in drug metabolism.

Patients do not disclose CAM use because they do not consider such information important, clinicians do not ask, and they think they may be misunderstood by traditionally trained physicians.[2] Similar to ongoing efforts of many pharmacy and nursing schools to enhance patient–clinician

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communication about CAM therapies, a few medical schools have begun to incorporate information on CAM into their undergraduate education curriculum.[11] Optimizing CAM use in the elderly requires educating clinicians and patients on what works, what hurts, and what may interact with other drugs.

Little information exists on patterns of use in very old people, the fastest growing segment of the US population. To begin to understand use patterns in the very old, we examined the prevalence and factors associated with herbs and vitamin–mineral supplements use among non-Hispanic white, black, and Hispanic adults aged ≥77 years living in Galveston County, TX.

Methods

SAMPLE

We used data from the 1997–1998 follow-up survey of a population-based sample of community-dwelling men and women aged ≥77 years living in Galveston County. The survey was done as part of the Health of the Public Study, a study in compliance with the requirements of the University of Texas Medical Branch Institutional Review Board/Human Subjects Research Committee. The baseline survey sample (N = 601) in 1995–1996 comprised 200 Hispanics, 201 blacks, and 200 non-Hispanic whites aged ≥75 years. Interviews were conducted in the subjects' homes in either Spanish or English, depending on the person's preference. Data collected included age, marital status, annual income, level of education, living arrangement, chronic medical conditions, self-reported health status, functional status, and number of physicians' visits, and emergency department use in the past year. Detailed information on medication use was collected at the 1997–1998 follow-up survey. A full description of sampling methods, data collection, and study protocols has been previously published.[12,13]

The present study included 365 subjects aged ≥77 years who were part of the original baseline survey sample (N = 601) and for whom data existed on relevant sociodemographic factors and health variables at the follow-up interview. Of the 236 subjects not included in the present analysis, 112 were deceased, 15 were residing in nursing homes, 33 had moved out of the area, and 76 had incomplete data at baseline or follow-up.

MEASURES

Herb and Vitamin–Mineral Supplements

Use of herbs and vitamin–mineral supplements was assessed by in-person interviews, using a previously established protocol.[14] Briefly, subjects were asked to show interviewers all drugs (including folk and over-the-counter agents) that they had taken or used in the past 2 weeks. The interviewers documented the drug's name and its dosage. Two geriatricians classified all entries as herb, vitamin, mineral, or other medication.

Independent Factors

Factors potentially associated with the use of herbs and vitamin–mineral supplements include sociodemographic variables (age, gender, ethnicity, marital status, years of formal education, household income, place of birth), self-reports of chronic medical conditions (diabetes, hypertension, coronary artery disease [CAD], cancer, emphysema, or chronic bronchitis), and global health rating assessed from responses to the question, "Overall, how would you rate your health: excellent, good, fair, or poor?". Healthcare utilization was assessed by number of physician visits in the past year (≤1, 2 or 3, and ≥4). Age was categorized into 2 groups: 77–79 years representing old and ≥80 years representing very old patients.

Functional disability was assessed by self-report of 7 items from a modified version of the Katz Activities of Daily Living (ADL) scale.[15] The scale asked respondents to report their ability to perform any of the ADLs, including walking across a small room, bathing, grooming, dressing, eating, transferring from a bed to a chair, and using the toilet. Cognitive function was assessed with a modified version of the Short Portable Mental Status Questionnaire, with ≥3 incorrect answers indicating a positive screen for cognitive impairment.[16,17] Depression symptoms were assessed with the 21-item Beck Depression Inventory, with a score of ≥15 indicating possible depression.[18]

Statistical Analysis

We examined demographic and health factors associated with use of herbs and vitamin–mineral supplements using descriptive contingency tables (χ^2, Fisher's exact test). Multivariate logistic regression models were used to identify factors associated with herbs and vitamin–mineral supplements use as a function of ethnicity by comparing users with non-users. The first (unadjusted) model included non-Hispanic white, black, and Hispanic ethnicity. The second model was adjusted for all variables with a p value ≤0.3 in bivariate analysis. All analyses were estimated using the SAS System for Windows, version 8 (SAS Institute, Cary, NC).

Results

Table 1 presents the characteristics of herb and vitamin–mineral supplements use in all subjects. Of the 365 subjects, 172 (47%) reported some supplement use: herbs alone, 21; vitamin–mineral supplements alone, 132; and both herbs and vitamin–mineral supplements, 19. Older non-Hispanic whites were significantly more likely to report using vitamin–mineral supplements (54.4% total use rate, comprising 44.8% alone plus 9.6% in combination with herbs) compared with older blacks (31.3% total use rate, comprising 25% alone plus 6.3% in combination with herbs) and older Hispanics (37.5% total use rate; none combined with herbs). Herbal use, alone or in combination with vitamin–mineral supplements, also varied by ethnicity: 12.8% (3.2% alone and 9.6% in combination with vitamin–mineral supplements) in non-Hispanic whites, 16.1% (9.8% alone and 6.3% in combination with vitamin–mineral supplements) in older blacks, and 4.7% (none combined with vitamin–mineral supplements) in Hispanics. Female gender, being born in the US, and having CAD were associated with use of herbs, while having ≥2 visits to a physician in the past year was significantly associated with use of vitamin–mineral supplements.

Table 2 presents logistic regression models for factors predicting use of herbs and vitamin–mineral supplements. Apart from female gender, no other factors were significantly associated with herb use. An increasing number of physician visits in the past year was associated with increased odds of vitamin–mineral supplements use; subjects with ≥4 physician visits in the past year were 2.08 times more likely to report use.

Table 3 presents a list of the herbs used by subjects in this study and some of the common health conditions for use of herbs. Because some participants used more than one herbal supplement, the frequency of use (53) exceeded the number of subjects reporting any use of herbs (40). The most commonly used herbs by our subjects were garlic, *Ginkgo biloba*, saw palmetto, and vinegar.

Discussion

Our findings confirm those of prior studies while pointing out the methodologic difficulties of such research. The

overall prevalence rate (47%) of CAM use is consistent with rates of 30–68% reported in past studies.[1-8] The wide range of prevalence rates of CAM use in the literature may, in part, be due to differences in duration and definition of the 27 types of CAM therapy.[2,3,5] On the other hand, the prevalence rate (a mere 4.7%) of herb use in our study sample of elderly Hispanics was much lower than rates reported in past studies of adults aged ≥65 years.[1,3,4,19] For example, in a study of 186 adults aged ≥65 years attending a senior health center, 77% of older Hispanics reported using herbs compared with 47% of older non-Hispanic whites, most commonly yerba buena, manzanilla, and poleo.[19]

One explanation for differing rates of herb use may be differing methods for ascertaining herb use: some studies collected information by telephone or mail-in surveys, while others verified herb use by in-person interviewers. It is also possible that our finding of lower herb use by older Hispanics may simply reflect past findings of lower rate of use of any medication by older Hispanics compared with older black and white people.[13,20,21] For instance, a study of 6171 community-dwelling persons aged ≥65 years found that, 78.8% of white and 82.5% of black participants were taking at least one prescription drug. These rates were higher than the use rate of 58.9% reported in a study of older Hispanics.[20,21]

Our findings of a lower rate of vitamin–mineral supplements use by older black respondents compared with non-Hispanic whites are consistent with those of past studies.[22,23] A study of 4862 adult participants of the 1999–2000 National Health and Nutrition Examination Survey showed vitamin–mineral supplements use rates of 23% in blacks and 20.5% in Hispanics compared with almost 40% in whites.[22] Another study of 130 community-dwelling adults aged ≥70 years reported a lower rate of vitamin–mineral supplements use in blacks compared with whites and Native Americans.[23] Given the potential benefits of vitamin–mineral supplements use in patients with cardiovascular diseases, it is not clear whether the lower use of these products by non-whites is associated with poor health outcomes.[9] Because no blood samples were obtained in this survey, we could not test the hypothesis of whether lower use of vitamin–mineral supplements in non-whites translates to increased risk of cardiovascular disease.

In line with prior studies on CAM use, our findings of an association of frequent physician visits with use of herbs and vitamin–mineral supplements suggested that elderly people using CAM still take conventional medicine.[2,24] For example, in a random telephone survey of 831 adults on CAM therapy, 79% of subjects rated combined use of conventional and alternative therapy as superior to either one alone.[2] Other characteristics associated with use of herbs and vitamin–mineral supplements included more education, poorer health, younger age, female gender, high income, and regular source of health care.[1,3,6,10,24,25] Our results thus extend previous studies to black, non-Hispanic white, and Hispanic adults aged ≥77 years, with an empha-

Table 1. Characteristics Associated with Use of Vitamin–Mineral Supplements and Herbs

Characteristic	Total[a] (n = 365)	Vitamins/ Minerals (n = 132) %	Herbs (n = 21) %	Vitamins/ Minerals and Herbs (n = 19) %	Nonuser (n = 193) %
Age (y)					
77–79	104	31.7	4.8	4.8	58.7
≥80	261	37.9	6.1	5.4	50.6
Gender[b]					
female	192	34.4	8.3	6.3	51.0
male	173	38.2	2.9	4.1	54.9
Ethnicity[b,c]					
non-Hispanic white	125	44.8	3.2	9.6	42.4
black	112	25.0	9.8	6.3	58.9
Hispanic	128	37.5	4.7	0.0	57.8
Education[d] (y)					
<6	119	39.5	7.6	1.7	51.3
7–9	77	33.8	3.9	7.8	54.6
≥10	136	33.8	5.9	7.4	52.9
Household income[d] ($)					
≤15 000	210	35.2	6.7	4.8	53.3
>15 000	101	34.7	4.0	7.9	53.4
Marital status[d]					
married	210	36.7	5.2	4.8	53.3
unmarried	135	34.1	6.7	6.7	52.6
Place of birth[b,d]					
US	292	36.0	6.5	6.5	51.0
other	50	32.0	2.0	0.0	66.0
Cognitive impairment[d]	92	39.1	6.5	3.3	51.1
ADL limitation[d]	45	35.6	6.7	2.2	55.6
Depressive symptoms (BDI ≥15)[d]	41	43.9	2.4	4.9	48.8
Self-rated health					
excellent/good	170	39.5	6.7	4.6	49.2
fair/poor	195	32.4	4.7	5.9	57.1
Medical conditions[d]					
cancer	65	38.5	6.2	6.2	49.2
CAD[b]	74	39.7	1.3	2.6	56.4
diabetes	56	16.7	4.8	10.5	16.2
emphysema or chronic bronchitis	26	46.1	3.9	3.9	46.1
hypertension	300	36.3	6.3	5.3	52.0
Number of physician visits[c,d]					
≤1	116	28.5	5.2	0.9	65.5
2–3	185	38.4	6.0	7.6	48.1
≥4	60	43.3	6.7	6.7	43.3

ADL = activities of daily living; BDI = Beck Depression Inventory; CAD = coronary artery disease.
[a]The percent is relative to the row total.
[b]p Value <0.05 for comparison between herb users and nonusers.
[c]p Value <0.05 for comparison between vitamin–mineral users and nonusers.
[d]Variables with missing values.

sis on ethnic differences in prevalence and correlates of herbs and vitamin–mineral supplements use in this population.

Limitations of our study were lack of information on reasons for herbs and vitamin–mineral supplements use, whether the subjects discussed use with their clinicians, whether the supplements were used concurrently with other drugs shown to the interviewers, and use for >2 weeks. Such information could be helpful in designing programs to improve patient–physician communication and reduce the likelihood of adverse drug interactions. Another limitation is the potential bias inherent in using follow-up subjects, especially with the death of nearly 20% of our baseline sample. Thus, our study sample may represent healthier people. Because poorer health has been shown to be positively associated with CAM use, the lower use of herbs by Hispanic elders in our study could represent an underestimation of use of these agents.[1,3,6,24,25] Despite these limitations, strengths of our data include its community-based triethnic sample of the very old and its inspection and documentation of supplements by the interviewers.

Conclusions

We found that 47% of adults aged ≥77 years reported using either herbs or vitamin–mineral supplements; Hispanics had the lowest rate of herb use, while blacks had the lowest rate of vitamin–mineral supplements use. Our findings indicate that inquiry about use of herbs and vitamin–mineral supplements should be a routine part of health care of the elderly. These findings also suggest that studies on potential efficacy and safety of these supplements in the very-old population need to recognize the inter-ethnic variations and predictors of use of these agents. Another important area for future investigation is the relationship between use of these agents in very old people and health outcomes in different ethnic groups.

Table 2. Logistic Regression Models for Factors Predicting Use of Vitamins/Mineral and Herbs

	Vitamins/Minerals		Herbs	
Independent Variables	**Unadjusted Model OR (95% CI)**	**Adjusted Model OR (95% CI)**	**Unadjusted Model OR (95% CI)**	**Adjusted Model OR (95% CI)**
Ethnicity (non-Hispanic white)				
black	0.38 (0.22 to 0.65)	0.37 (0.21 to 0.65)	1.31 (0.63 to 2.70)	1.21 (0.55 to 2.65)
Hispanic	0.50 (0.30 to 0.83)	0.56 (0.30 to 1.03)	0.34 (0.13 to 0.89)	0.54 (0.19 to 1.59)
Age (77–79 y)		1.46 (0.87 to 2.45)		1.28 (0.56 to 2.93)
Gender (male)		0.92 (0.58 to 1.46)		2.14 (1.00 to 4.59)
Place of Birth (US)		0.71 (0.33 to 1.53)		0.27 (0.03 to 2.35)
Diabetes		NA		0.58 (0.16 to 2.12)
Coronary artery disease		NA		0.33 (0.10 to 1.15)
Self-rated health (excellent/good)		1.14 (0.72 to 1.80)		NA
Number of pysician visits (≤1)				
2–3		1.82 (1.08 to 3.08)		2.54 (0.98 to 6.59)
≥4		2.08 (1.04 to 4.15)		2.93 (0.91 to 9.43)

NA = not included in the analysis when p >0.3 in the bivariate analysis. The reference categories are given in parentheses.

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EXTRACTO

TRASFONDO: Existe poca información sobre el uso de hierbas y suplementos de vitaminas y minerales en los muy ancianos y si el uso varía con el grupo étnico.

OBJETIVO: Examinar la prevalencia y factores de predicción del uso de hierbas y suplementos de vitaminas y minerales en una muestra de 3 grupos étnicos de adultos mayores de 77 años de edad.

MÉTODOS: Entrevistas en el hogar durante el 1997–1998 evaluaron el uso de medicamentos y factores socio-demográficos y de salud en adultos ancianos blancos no hispanos (n = 125), negros (n = 112), e hispanos (n = 128).

RESULTADOS: De los 365 sujetos (71.5% ≥80 y, 52.6% mujeres), 172 reportaron usar por lo menos uno de los fármacos: suplementos de vitaminas y minerales, n = 132; hierbas solas, n = 21, y ambos hierbas y suplementos de vitaminas y minerales, n = 19. El uso de hierbas varió con el grupo étnico: 12.8% en blancos no hispanos, 16.1% en negros, y 4.7% en hispanos. Las hierbas usadas más comúnmente fueron ajo, ginkgo biloba, saw palmetto, y vinagre. El uso de suplementos de vitaminas y minerales, sólo o en combinación con hierbas, también varió por grupo étnico: 54.4% en blancos no hispanos, 31.3% en negros, y 37.5% en hispanos. En el modelo de variables múltiples completamente ajustado y usando como referencia el grupo étnico blanco, la proporción de la probabilidad del uso de suplementos de vitaminas y minerales para los negros fue 0.37 (95% CI 0.21 a 0.65) y para los hispanos fue 0.56 (95% CI 0.30 a 1.03). En los análisis bivariables, el sexo femenino, el grupo étnico negro, el haber nacido en los Estados Unidos, y el tener enfermedad arterial coronaria estuvieron asociados significativamente con el uso de hierbas ($p < 0.05$); sin embargo, en el modelo de variables múltiples completamente ajustado, solo el sexo femenino continuó asociado significativamente con el uso de hierbas (OR 2.14; 95% CI 1.00 a 4.59).

CONCLUSIONES: El uso de hierbas o vitaminas y minerales es común en los muy ancianos y varía con el grupo étnico.

Brenda R Morand

Table 3. Herbal Products and Their Common Uses[5,6,10,25]

Herbs	Frequency of Use	Use
Alfalfa	2	hypoglycemic, diuretic
Aloe	2	wound-healing agent
Aniseed	1	antitussive, mucolytic
Cat's claw	1	antiinflammatory, antigastritis
Cayenne pepper	1	antimicrobial, analgesic
Chamomile	3	sedative, antinausea
Cranberry	2	antiinfective, antiinflammatory
Flaxseed	2	laxative, skin antiinflammatory
Garlic	12	hyperlipidemia, antiplatelet
Ginger	3	antiemetic, antiinflammatory
Ginkgo biloba	5	intermittent claudication, memory loss
Honey	2	antitussive, expectorant
Olive leaf	2	analgesic, antigout
Saw palmetto	5	urinary analgesic, for enlarged prostate
St. John's wort	3	antidepressant
Valerian root	2	anxiolytic, hypnotic
Vinegar	5	antimicrobial

RÉSUMÉ

HISTORIQUE: Peu d'information est disponible concernant l'utilisation de plantes médicinales et de suppléments de vitamines et de minéraux chez les personnes très âgées et à savoir si leur emploi varie selon l'origine ethnique.

OBJECTIF: Déterminer la prévalence et les facteurs prédictifs d'emploi de plantes médicinales et de suppléments de vitamines et de minéraux dans un échantillon d'adultes de plus de 77 ans et représentant 3 ethnies différentes.

MÉTHODOLOGIE: Des entrevues réalisées à domicile en 1997 et 1998 ont permis d'évaluer les facteurs sociodémographiques, les facteurs liés à l'état de santé ainsi que le niveau d'utilisation de ces produits chez des membres âgés de communautés blanche non hispanique (n = 125), noire (n = 112), et hispanique (n = 128).

RÉSULTATS: Des 365 sujets, dont 71.5% ont ≥80 ans et 52.6% sont des femmes, 172 ont admis avoir consommé au moins l'un des produits suivants: suppléments de vitamines et de minéraux (n = 132), plantes médicinales seules (n = 21), et suppléments de vitamines et de minéraux et plantes médicinales (n = 19). L'utilisation des plantes médicinales varie selon l'ethnicité: taux d'utilisation de 12.8% chez les blancs non hispaniques, 16.1% chez les noirs, et 4.7% chez les hispaniques. Les plantes les plus utilisées sont l'ail, le gingko biloba, le chou palmiste, et le vinaigre. L'utilisation des suppléments de vitamines et de minéraux, seuls ou associés aux plantes médicinales, a elle aussi varié selon l'ethnicité: taux d'utilisation de 54.4% chez les blancs non hispaniques, 31.3% chez les noirs, et 37.5% chez les hispaniques. Dans l'analyse multivariance adaptée et utilisant l'ethnie blanche comme référence, le rapport de cote de l'utilisation des suppléments de vitamines et de minéraux chez les noirs était de 0.37 (IC 95% 0.21 à 0.65) et chez les hispaniques était de 0.56 (IC 95% 0.30 à 1.03). Dans l'analyse bivariance, les facteurs suivants, le sexe féminin, l'ethnie noire, la naissance en territoire américain, et la présence de maladie coronarienne athérosclérotique, ont été associés de façon significative à l'emploi de plantes médicinales ($p < 0.05$); cependant, dans l'analyse multivariance, seul le sexe féminin demeurait un facteur significatif lié à l'emploi de plantes médicinales (RC 2.14, IC 95% 1.00 à 4.59).

CONCLUSIONS: L'utilisation de plantes médicinales et de suppléments de vitamines et de minéraux chez les personnes très âgées est fréquente et varie selon l'origine ethnique.

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