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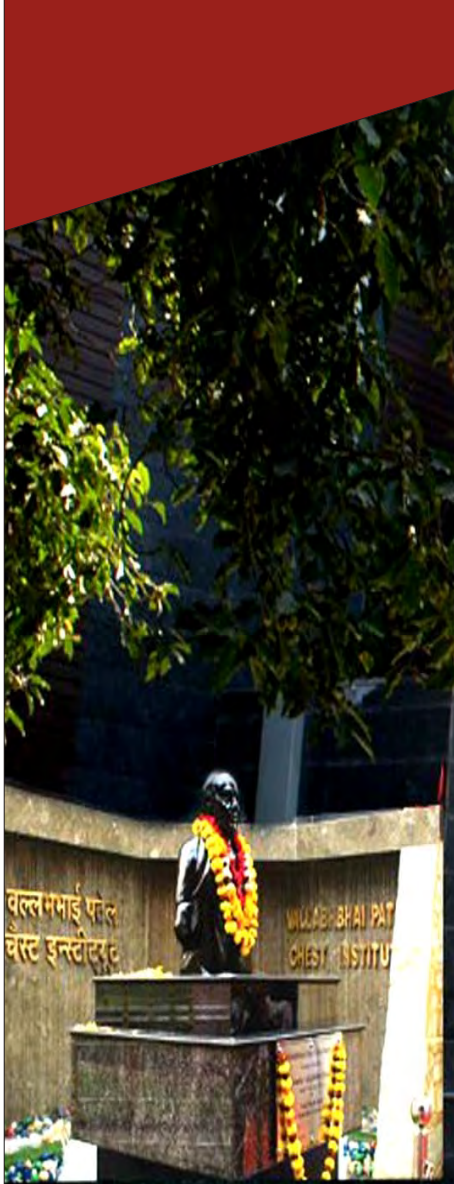

GSICON 2016

13th International Conference on Geriatrics & Gerontology

Highlights

- Chronic Cough in Elderly
- Geriatric Care, Education and Research in Geriatrics
- Strategies to Combat Diabetes in Indian Geriatric Population
- Status and scope of Education in Geriatric Medicine in India
- COPD in Elderly: Let's Rejuvenate the Ageing Lungs
- Frailty Syndrome
- Influenza from an International Perspective

In pursuit of excellence in Geriatric Care

Bharat Nursing Home

Sonepat Road, Rohtak

Editorial Board

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CONTENT

IJGC
INDIAN JOURNAL OF GERIATRIC CARE

MESSAGES

ORATIONS

PRESIDENTIAL ORATION - 2016

DR. J. J. RAO ORATION

DR. RAGHUNANDAN LAL ORATION

DR. B. C. BANSAL & DR. C. PRAKASH ORATION

DR. B. N. SRIVASTAVA & SARAN DULARI ORATION

GUEST LECTURES

ABSTRACTS

GSI NEWS

डॉ. हर्ष वर्धन
DR. HARSH VARDHAN

सत्यमेव जयते

मंत्री
विज्ञान और प्रौद्योगिकी एवं पृथ्वी विज्ञान
भारत सरकार
नई दिल्ली - 110001

MINISTER
SCIENCE & TECHNOLOGY AND EARTH SCIENCES
GOVERNMENT OF INDIA
NEW DELHI - 110001

MESSAGE

I am very happy to know that Geriatric Society of India jointly with Vallabh Bhai Patel Chest Institute is organizing 13th International Conference on Geriatrics & Gerontology.

I am also happy to know that this noble cause is supported by Influenza Foundation of India, National College of Chest Physicians, APACI, IFPMA & Stop Tobacco Campaign is organizing Geriatric Society of India for last many decades is engaged in drawing the attention of planners, scientists, medicos & para-medicos in this country towards the special aspects of their medical needs.

The society is actively engaged in updating all Geriatric Care givers.

I am sure the deliberation during this conference & interaction between participants from India & abroad will be fruitful in the direction of better care for elderly patients.

On this occasion, I wish the organizers & participants all the success in their endeavour of better medical care for elderly.

Harsh

(Dr. Harsh Vardhan)

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जगत प्रकाश नड्डा
Jagat Prakash Nadda

स्वास्थ्य एवं परिवार कल्याण मंत्री
भारत सरकार
Minister of Health & Family Welfare
Government of India

I am very pleased to learn that the Geriatric Society of India is organizing its Annual Conference GSICON 2016 at Delhi from 10th – 11th December, 2016.

India has the second largest elderly population in the world and its 11.5 crore elderly require social, financial, legal and medical attention. The Annual Conference of GSI is a commendable step to support the elderly through updating the doctors and paramedics regarding geriatric medical issues and their management.

I congratulate the organizers and the participants of the Conference and extend my best wishes for its success.

(Jagat Prakash Nadda)

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Patron: Geriatric Society of India

MESSAGE

Over the last century life expectancy has increased dramatically. The number of elderly is rising all over the world including India. The population of elderly persons in our country is increasing making it a 'graying nation'.

The number of elderly persons is overtaking the number of the young resulting in a huge demographic shift threatening to overwhelm Nation's economic and social problems. Though no skill is needed to grow old, Henri Amiel has considered that, 'to grow old is the master-work of wisdom, and one of the most difficult chapters in the great art of living'. Today more and more people are destined to live into their eighties and it has necessitated them to gain the knowledge of growing old gracefully.

Graceful ageing can only occur in a healthy body. This statement probably answers the puzzle of restoration of youth. Healthy ageing requires an immune system that is working properly. It helps to prevent or slow the process of disease and regulates the speed of ageing process. Elderly population comprises people who have given their best during their productive years to the Society and to the Nation. These people are still a part of our main stream which is being benefited by their experience. The elderly is living in a private Universe of physical weakness and mental decay. There is a great need to focus our attention towards their medical and health needs.

According to a study of Adult Development carried out at Harvard University, people become mellowed with age. The features like forgiveness, gratitude, and compassion will lead to successful aging. The Study has given ingredients essential to successful living. It has said, 'old age can be both miserable and joyous. But the positive aging must reflect vital reactions to change, to disease and to conflict'. The goal is straightforward to achieve successful aging.

Since ageing appears to be the only available way to live a long time, and the number of geriatric population is on increase in the country, there is an urgency to address the health issues of this growing mass of population as a separate segment. We have to strive to make these individuals to show features of positive ageing. Successful ageing, then becomes giving to others with joy, and receiving it gratefully during needs.

Prof. S.N. Gaur
President
Geriatric Society of India
Director (Acting) and Head, Pulmonary Medicine,
V. P. Chest Institute, University of Delhi, Delhi

MESSAGE

It is an auspicious occasion for all of us that Geriatric Society of India jointly with Influenza Foundation of India, APACI, NCCP, IFPMA & STC is organizing a unique conference on Geriatrics & Gerontology on 10-11 December 2016 at VP Chest Institute, Delhi.

The scientist & geriatric care givers will exchange views regarding the special aspects of diseases & their management in elderly population.

I am sure this will be an excellent platform for updating oneself about the uniqueness of geriatric medicine.

I am sure the organizing committee will provide an excellent scientific feast to the delegates.

With good wishes

Chronic Cough in Elderly

*S.N. GAUR

Cough, despite being protective physiologic reflex for clearance of airway secretions, is one of the most common symptom in primary care referrals and for pulmonologist consultations. Chronic cough i.e., cough lasting more than 8 weeks, is a very distressing symptom. This is particularly true for the elderly (age > 65years) already suffering from preexisting health problems and complicated social, economic and psychological burdens.[1,2] Considering normal physiology of lung ageing , there is age related decline of lung functions and the elasticity of lung parenchyma, which can otherwise produce cough, but mainly after exertion. The elderly patients require special attention since pharmacokinetics and pharmacodynamics of drugs vary in them compared to the young and also they may be on other medications leading to drug interactions.

Upper airway cough syndrome (UACS), cough-variant asthma (CVA), gastroesophageal reflux disease (GERD) and eosinophilic bronchitis are identified as the major causes of chronic cough in adults.[3] There are limited studies to elucidate the causes of chronic cough in the elderly. The cough variant asthma and upper airway cough syndrome are the common causes of chronic cough in elderly. Many of the elderly patients are on antihypertensive or cardiac medications like angiotensin converting enzyme inhibitors (ACEI), which are other cause of chronic cough in the elderly. ACEI-induced cough and gastro-oesophageal reflux disease (GERD) have been shown to be more prevalent in elderly patients than in non-elderly patients.[4]

The common chronic respiratory diseases of the elderly, such as asthma and smoking associated COPD, are other important causes of chronic cough. COPD is projected to become the third leading cause of death by 2030.[5] Despite this, these conditions are frequently underdiagnosed because the elderly tend to underreport their respiratory symptoms. Also, they frequently consider these as natural features of ageing and feel that medical intervention might be of little help. Another important cause of chronic cough in elderly is heart failure especially to be suspected in known cases of hypertension, diabetes mellitus and coronary artery disease. It is usually associated with dyspnea and orthopnea / paroxysmal nocturnal dyspnea.

The importance of tuberculosis as cause of chronic cough in elderly cannot be undermined considering the high prevalence of tuberculosis in India. The classic constitutional symptoms of low grade fever, anorexia and weight loss seen in tuberculosis may often get overlooked as natural ageing process making a delay in diagnosis. Bronchogenic carcinoma should be considered as a possible cause of a new cough or a change in chronic "smoker's cough". The danger signs like hemoptysis, sudden weight loss, anorexia and chest pain may be pointer towards malignancy.

Bronchiectasis is also one of the differentials of chronic cough in the elderly and is usually associated with episodes of exacerbation with increased quantity and/or purulence of sputum.

The approach to chronic cough in elderly requires a good medical history which can give important clues for the diagnosis. History of belching, heartburn points towards GERD whereas drug history may reveal intake of ACEI as cause of chronic cough. Repeated throat clearing or post nasal drip suggests UACS and paroxysmal cough with dyspnea is suggestive of asthma. History of smoking raises possibility of COPD as the probable cause. Other co-morbidities should be explored as well as the possibilities of inter drug side effects due to drugs he may be taking for other diseases.

The diagnosis is confirmed by investigations like chest x ray, spirometry, sputum for AFB and cytology, CT-paranasal sinuses and other investigations as appropriate.

In conclusion, symptom of chronic cough in elderly shares similar differentials like in adults. Hence, chronic cough in elderly should be evaluated in the same manner and treated accordingly. Sometimes there may be more than one etiological causes of cough requiring attention for the complete treatment. Also, the treating physician should be mindful of the considerable emotional and physical morbidity caused by chronic cough in elderly.

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Geriatric Care, Education and Research in Geriatrics

*M.S. SRIDHAR

GENERAL

The ethos of Bharatavarsha has always been respect towards elders in the family and society.

अभिवादन शीलस्य नित्यं वृद्धोपसेविनः।
चत्वरि तस्य वर्धन्ते आयुर्विद्या यशोबलम्।।
abhivAdana shIlasya nityaM vRuddhopasevinaH |
chatvAri tasya vardhante AyurvidyA yasho balam ||

One who daily bows to the elders in the house and seeks their blessings is said to get four boons- his lifetime or longevity, learning skills, fame and power among his people and strength which grows day by day.

The Western thought on long life is fairly portrayed by Ben Johnson as :

It is not growing like a tree
In bulk doth make Man better be,
Or standing long an oak, three hundred year,
c a log at last, dry, bald, and sere.

The meaning is conveyed that one has to live a lively and healthy and long life and mere years of life is not sufficient.

Two hundred years of colonial rule and introduction of educational 'reforms' and the phenomena of industrialization, urbanization, westernization and modernization and later globalization and liberalization have brought in their wake profound changes in the lives of elderly. The health and medical care of elderly have, consequently, followed developments in the Western countries, notably the UK and the US. Specialization based on organ systems and age is the order of the day. Stress on tertiary medical care and Corporatization of medical care and the culture of old age homes is gaining ground at a faster pace than expected. The 'ageing population' of the Nation has drastically altered the demographic structure with an increasing proportion of persons aged 60 and above which is about 8 per cent of the population that is equivalent to a large State in the Union of India and the sad part of it is that one third of them live alone. In consonance with the International consensus, the elderly are recognized as vulnerable section of the society and the inclusive social development is meaningful only when the concerns of the elderly who have contributed for the sustained development during their life time are addressed.

WHY GERIATRICS

Geriatrics is just not General Medicine as applied to older persons. There are unique phenomena especially applicable to them. Abrupt decline in any system is always due to disease and not to normal ageing. In the absence of disease, decline in homeostatic reserve causes few symptoms. In the elderly there is underreporting of illness and the symptoms may be 'missing' or 'masked'. There are barriers to history like confusion, deafness, lack of concentration, lack of cooperation and idiosyncrasy.

Geriatric patients are more heterogeneous than young adult patients. Recognition of uniqueness of each patient and attention to commonalities among them defines the approach. The commonalities among geriatric patients are more complex and go beyond age, specific disease, or particular organ system. Geriatric patients often have multiple chronic disease conditions and the sequelae of those conditions and those of their treatments. They are more vulnerable to 'acute illness' due to 'homeostenosis' and disability. Because of limited physiological reserve, the person presents early in the natural history. Clinical situations are ambiguous and complications are common. Atypical presentations, partial syndromes and equifinality or different conditions presenting with same complaint/s and syndrome is the rule. Diagnostic decision does not obey 'the law of parsimony'. A problem oriented approach may be extremely useful in addressing the concerns of the 'old patient'.

Care of the elderly requires appropriately well trained multidisciplinary, family oriented caring teams, a strategy that is yet to be perfected in our setting. In implementing pharmacological treatment it is to be remembered that due to reduced serum albumin there is diminished plasma drug protein binding and adverse reactions can be avoided or

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minimized by adjusting the dosage. The adverse effects are predictable, dose dependent and common manifestations of toxicity are to be expected. The range of therapeutic index is often narrow.

PRINCIPLES OF CARE

CLIENTELE'S EXPECTATIONS FOR CARER AND CARER'S EXPECTATION FOR CLIENTELE

In Geriatrics it is a truism that we are able to cure rarely, can bring relief often but certainly can care always. Nowhere is this truth more evident than in the practice of geriatrics. The main reasons for this situation are multiple disorders or problems, polypharmacy and attendant adverse effects following it and poor accessibility to and affordability for the essential services. Like a child, quite often, the elderly crave for love, affection and attention of the family members, often dependent on family members and still cannot let go their hold or authority on them without despair. This may lead to 'abnormal illness behaviour' (AIB) which may be magnifying the symptoms as a part of attention seeking or bearing with them stoically in order not to inconvenience the younger members of the family. The need for communication with the clientele and their family members for planning acceptable care is of paramount importance for the successful care.

ROLES OF GERIATRICIAN, PRIMARY CARE PROVIDER AND SPECIALISTS

Every health professional and carer should have appropriate level of awareness about the geriatric conditions and their possible solutions with an eye on cost-effectiveness. Effectiveness implies restoring the ability to carry on independently and take care of the self with a sense of autonomy and dignity. Primary care provider, especially Family Physician is more conversant with the health behaviour of the individual over a period of time and is in the vantage position to assess and evaluate the elderly person's health condition and thus plan appropriate care. Geriatrician provides consultation for specific problems or issues of concern raised by the primary provider and can plan a multidisciplinary approach and execute it for a while and hand over the patient to the primary care provider. He provides all the support including inpatient service when needed. In a way, he provides the educational support to enhance knowledge and skill of the primary provider. The role of family members, as informal care providers, cannot be overemphasized. Family Physician is the key to the health of the elderly person in the family.

EDUCATIONAL IMPLICATIONS

The sheer magnitude of the ageing population makes it imperative to organize medical and health care for elderly, based on principles of inclusiveness and primary care approach including the guiding principles of Long Term Care (LTC) tailored to the cultural milieu. This will understandably have cascading effect on Medical Education Curricula at both under graduate and post graduate levels.

The position of Geriatrics as a specialization and the need to foster proper attitudinal and behavioural changes in student community in general vis-à-vis elderly needs to be reckoned with. Identification of specific needs of the elderly in terms of their background, life events and provision of a range of services to cater to their biopsychosocial needs define the care of the elderly. The Departments of Community Medicine and Family Medicine should provide leadership by practical demonstration of 'adding life to years'. Training of 'Teams' consisting of individuals from different disciplines takes precedence over training individuals belonging to one discipline. Some of the ways to motivate the students to evince interest in old age issues are by involving them in the study and care of the elderly following the famous aphorism of Peabody that "the secret of caring is caring itself".

There is so much accumulated experience in Long Term Care (LTC) that is documented, in last two decades, based on experience of a number of countries including Sri Lanka, that GSI should focus attention on collating our own rich experience of home care, informal care and lastly Institutional Care. The best care is the one that is based on home and family. This has to be reinforced and further nurtured. 'Shravan Kumars' have to be recognized and honoured.

GERIATRICS AS PART OF CURRICULUM

At present, Medical Council of India Regulations on Graduate Medical Education merely mentions, under the head 'Knowledge' or Cognitive component, in the objectives for General Medicine, that "at the end of the course, the student should be able to recognize geriatric disorders and their management". The clinical training is to be carried out in the settings of out-patient department, Emergency Department and within the community including peripheral health care institutions. They are expected to gain maximal experience through contacts with patients and the communities in which they live. This will enable them to appreciate the importance of social factors in relation to the problem of health and disease.

LEARNING IN THE COMMUNITY

Rural Health Training Centre, Primary Health Centres, Urban Health Centres and visits to families offer scope for first hand learning of dynamics of community diagnosis and hone the skill of the individual professional to practice advocacy for the marginalized including elderly people. They can understand the reality of 'Ageism' and violence against

the aged. With the assistance of Medico Social Workers and social psychologists, the issues can be identified and possible solutions are identified. Though the Government of India has formulated the 'National Policy on older persons' as early as 1999 and the Parliament enacted "Maintenance and Welfare of Parents & Senior Citizens Act" in 2007 and as a follow up initiated a National Programme for Health Care of the Elderly (NPHCE), the progress achieved in realizing the objectives are not fully satisfactory. A wholesome consensus and implementation effectively by integrating with General Health Services is the need of the hour. Appropriate training and orientation of professionals and informal care givers have to be put in place urgently.

SPECIAL ASPECTS OF GERIATRICS

As quoted by Bengoa, "while what is possible is done, what needs to be done should not be forgotten." First things must come first. Prioritization of the needs of the elderly saves the scarce resources. The epidemiology of Multiple morbidities, Cognitive impairment, Frailty, Homeostenosis (impaired homeostasis), Disability, Sarcopenia, Malnutrition and Chronic inflammation which have been identified as important problems of elderly, needs to be repeatedly documented to find viable solutions in the prevailing ecological milieu.

DOCUMENTATION OF THE EXPERIENCE AND DISSEMINATION OF INFORMATION - COMMUNITY HEALTH EDUCATION- IEC ACTIVITIES

That old age is but one stage in life and there are methods available to ameliorate the suffering needs to be discussed with opinion leaders and information has to be widely disseminated. The education of the young minds about the need to take care of their elders as a necessary part of their life activities is the need of the hour. Every opportunity has to be seized upon to demonstrate how the elders benefit from scientific advancements and how their wisdom can be harnessed for the benefit of the young. That Geriatric population and the young both stand to benefit by symbiotic relationship and the progress of the young will become additive; and that neglecting the concerns of geriatric population may result in colossal wastage of accumulated wisdom and as that the young will have to reinvent the wheel once again should not be lost sight of. The I E C activities have to be sensitive to the cultural milieu and the mores, the essential or characteristic customs and conventions of a society or community and taboos, a social or religious custom prohibiting or restricting a particular practice or forbidding association with a particular person, place or thing of the society should not be palpably transgressed so that assimilation by the society of the new practices becomes smoother and does not unsettle the socio-cultural equilibrium. Though euthanasia is not approved in our Country, the Jain religious practice of 'Santhara', a ritual by which the person ends life by fasting is not legally prohibited and is still respected and revered. Is it not similar to the Modern Medicine's axiom that Advance Directives of Terminally Ill should be recorded and respected?

RESEARCH PRIORITIES IN CARE AND EDUCATION

Trans-disciplinary research and innovation based on indigenous practices appear to provide at least a few of the viable solutions for myriad problems with which the elderly have to cope up with. Research focussed on determinants of 'Wellness' and 'Positive Health' are likely to provide cost-effective acceptable solutions which are replicable. The experience from different geographic areas needs to be systematically analyzed, documented and disseminated with timely follow up suitable modification of programme content and management practices so that 'life can be added to the years'. The diversity and variegated socio-cultural milieu in India requires that the experience of one area can be adapted suitably for another area.

CONCLUSION

Promoting health enhancing practices from childhood and availability and affordability for a range of services which will protect the elderly from misery of disease and disability without compromising autonomy and self respect will lead to ego integrity for the elderly. Enhancing the purchasing power of the elderly coupled with social security measures that include access to health services and goods will allow them to negotiate the old age successfully. Then the 'second childhood' will not be viewed with dread by the 'senior citizen' and the surviving generation will be spared from the psychological distress and the guilt and thus, enhance their own health. If we extend the exposition about affection towards others as portrayed in Brihadaranyakopanishad, it can be said that "Verily, it is not for the sake of the elders that the elders are dear, but for the sake of the self the elders are dear". If this concept gets internalized, then taking care of the elderly becomes a natural trait.

Can 'jyogjivaa jarama simahi', ageing gracefully, become a reality or remain a mirage?

Today and now, is the time to act decisively and continually to make it a reality. I believe all of us are ready to shoulder the responsibility of shaping a future generation that does not ignore the needs of the elderly persons.

JAI HIND

Strategies to Combat Diabetes in Indian Geriatric Population

*M.V. JALI

INTRODUCTION

Ageing is an ongoing process. Geriatric health concerns diabetes, nutritional deficiency, stress & sleep problems, loss of immunity, osteoarthritis & osteoporosis, cardiovascular diseases and not the least, cancers. Every elderly deserves a blend to manage their health burden for better well-being. Central Statistics Office, Ministry of Statistics & Programme Implementation, Government of India, in its report during 2011, gave a Situation Analysis of The Elderly in India. In India, the size of the elderly population, i.e. persons above the age of 60 years is fast growing although it constituted only 7.4% of total population at the turn of the new millennium. Growing faster. Indian Geriatric Population is expected to triple by 2050.

OLD AGE AND DIABETES

Diabetes is an important health condition for the Ageing population; at least 20% of patients over the age of 65 years have diabetes, and this number is expected to grow rapidly in the coming decades. Older individuals with diabetes have higher rates of premature death, functional disability, and coexisting illnesses, such as hypertension, coronary heart disease, and stroke than those without diabetes. Older adults with diabetes are also at a greater risk than other older adults for several common geriatric syndromes, such as poly-pharmacy, cognitive impairment, urinary incontinence, injurious falls, and persistent pain. Screening for diabetes complications in older adults also should be individualized. Older adults are at an increased risk for depression and should, therefore, be screened and treated accordingly.[1] Particular attention to complications that can develop over short periods of time and/or that would significantly impair functional status, such as visual and lower-extremity complications.[2]

The long-term care of older adults with diabetes is complicated by their clinical and functional heterogeneity. Some older individuals developed diabetes years earlier and may have significant complications; others are newly diagnosed and may have had years of undiagnosed diabetes with resultant complications, and still other older adults may have truly recent-onset disease with few or no complications. Some older adults with diabetes are frail and have other underlying chronic conditions, substantial diabetes-related co-morbidity, or limited physical or cognitive functioning. Other older individuals with diabetes have little comorbidity and are active. [3,4] Life expectancies are highly variable for this population but are often longer than clinicians realize. Providers caring for older adults with diabetes must take this heterogeneity into consideration when setting and prioritizing long-term care & treatment goals in elderly.(ADA, Table: 1)

STRATEGIES TO COMBAT DIABETES AND TREATMENT GOALS IN OLDER ADULTS

There are few long-term studies in older adults demonstrating the benefits of intensive glycemia, blood pressure, and lipid control. Patients who can be expected to live long enough to reap the benefits of long-term intensive diabetes management, who have good cognitive and physical function, and who choose to do so via shared decision making may be treated using therapeutic interventions and goals similar to those for younger adults with diabetes. As with all diabetic patients, diabetes self-management education and ongoing diabetes self-management support are vital components of diabetes care for older adults and their caregivers. For patients with advanced diabetes complications, life-limiting co-morbid illness, or substantial cognitive or functional impairment, it is reasonable to set less intensive glycemic target goals. These patients are less likely to benefit from reducing the risk of microvascular complications and more likely to suffer serious adverse effects from hypoglycemia. However, patients with poorly controlled diabetes may be subject to acute complications of diabetes, including dehydration, poor wound healing, and

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hyperglycemic hyperosmolar coma. Glycemic goals at a minimum should avoid these consequences.[5]

Diabetes mellitus (DM) is a major health problem for the ageing population. Glycemic control is fundamental to the management of diabetes, as glycemic levels are closely linked to the development of diabetes-related complications. Measurement of the hemoglobin A1c (A1c) to assess chronic glycemic control is an integral component of diabetes care. Currently, there is no clear evidence that age alters the relationship between A1c and average blood glucose. The Diabetes Control and Complications Trial and the United Kingdom Prospective Diabetes Study are the two most important studies that have provided evidence leading to the general recommendation of A1c monitoring. The American Diabetes Association recommends achieving an A1c level of 7% or lower. However, older diabetics represent a heterogeneous population ranging from frail nursing home residents to active community-dwelling elderly with variable life expectancies. One needs to look at the individual to best balance risk versus benefit associated with the tight glycemic control. Benefits of intensive therapy to lower A1c must always be weighed against the greater risk of disabling and unpredictable hypoglycemia, as the geriatric population is less likely to take advantage of reducing the risk of microvascular complications and more likely to suffer serious adverse effects from hypoglycemia.[6]

Dorner[7] guidelines allow for liberalization of the dietary treatment of diabetes in people with type 2 diabetes in long-term care facilities. The care team should work together to promote specific policies and protocols in the facility to address how individual type 2 diabetics will be assessed, and which diets will be offered as an adjunct to treatment. Careful monitoring of blood glucose levels, medications and response to treatment may allow for more liberalization of the diet. Diet liberalization can help to promote better health and improved quality of life for our elderly residents.

Although hyperglycemia control may be necessary for older individuals with diabetes, greater reductions in

Table : Framework for considering treatment goals for glycemia, blood pressure, and dyslipidemia in older adults with diabetes

Patient characteristics / health status	Rationale	Reasonable A1C goal‡	Fasting or pre-prandial glucose (mg/dL)	Bedtime glucose (mg/dL)	Blood pressure (mmHg)	Lipids
Healthy (few coexisting tolerated chronic illnesses, intact cognitive and functional status)	Longer remaining life expectancy	<7.5%	90–130	90–150	<140/90	Statin unless contraindicated or not
Complex/intermediate (multiple coexisting chronic illnesses* or 2+ instrumental ADL impairments or mild-to-moderate cognitive impairment)	Intermediate remaining life expectancy, high treatment burden, hypoglycemia vulnerability, fall risk	<8.0%	90–150	100–180	<140/90	Statin unless contraindicated or not tolerated tolerated
Very complex/poor health (long-term care or end-stage tion chronic illnesses** or moderate-to-severe cognitive impairment or 2+ ADL dependencies)	Limited remaining life expectancy makes benefit uncertain	<8.5%†	100–180	110–200	<150/90	Consider likelihood of benefit with statin (secondary preven- more so than primary)·

This represents a consensus framework for considering treatment goals for glycemia, blood pressure, and dyslipidemia in older adults with diabetes. The patient particular categories are general concepts. Not every patient will undoubtedly fall into a particular category. Consideration of patient and caregiver preferences is an important aspect of treatment individualization. Additionally, a patient's health status and preferences may change over time. ADL, activities of daily living.

· !‡ A lower A1C goal may be set for an individual if achievable without recurrent or severe hypoglycemia or undue treatment burden.

· !* Coexisting chronic illnesses are conditions severe enough to require medications or lifestyle management and may include arthritis, cancer, congestive heart failure, depression, emphysema, falls, hypertension, incontinence, stage 3 or worse chronic kidney disease, myocardial infarction, and stroke. By "multiple," we mean at least three, but many patients may have five or more (6).

· !** The presence of a rare end-stage chronic illness, such as stage 3–4 congestive heart failure or oxygen-dependent lung disease, chronic kidney disease requiring dialysis, or uncontrolled metastatic cancer, may cause significant symptoms or impairment of functional status and significantly reduce life expectancy.

· !† A1C of 8.5% equates to an estimated average glucose of <"200 mg/dL. Looser glycemic targets than this may expose patients to acute risks from glycosuria, dehydration, hyperglycemic hyperosmolar syndrome, and poor wound healing.

*Suggested citation: American Diabetes Association. Older adults. Sec. 10. In Standards of Medical Care in Diabetes—2015. Diabetes Care 2015; 38(Suppl. 1): S67–S69

morbidity and mortality are likely to result from control of other cardiovascular risk factors rather than from tight glycemic control alone. There is substantial evidence from clinical trials of the value of treating hypertension in the elderly. [4,5] There is less evidence for lipid-lowering and aspirin therapy, although the benefits of these interventions for primary and secondary prevention are likely to apply to older adults whose life expectancies equal or exceed the time frames seen in clinical trials.

Hypoglycaemia & Hyper-glycaemia

With the Ageing of the population and longer life expectancies, the prevalence of population with multiple chronic medical conditions has increased. Difficulty managing these conditions as people age (because of changes in physical, functional, or cognitive abilities and the complexity of many treatment regimens), has led to more individuals with multiple medical conditions admitted to the long-term care facilities. Older adults with diabetes residing in the long-term facilities represent the most vulnerable of this cohort.

Studies that specifically target diabetes management in older population are lacking, and those that target diabetes management in the long run care facilities are even fewer. The lack of knowledge regarding the care of the elderly residing in long-term care with diabetes may lead to treatment failure and a higher risk of hyperglycemia, as well as hypoglycemia. In ageing populations, hypoglycemia has the potential for catastrophic consequences. To avoid this, the management of older population with diabetes and other medical co-morbidities residing in long-term care facilities requires a more holistic approach compared with focusing on individual chronic disease goal achievement.[8]

Older adults are at a higher risk of hypoglycemia for many reasons, including insulin deficiency and progressive renal insufficiency. Also, older adults tend to have higher rates of unidentified cognitive deficits, causing difficulty in complex self-care activities (e.g., glucose monitoring, and adjusting insulin doses). These deficits have been associated with increased risk of hypoglycemia and with severe hypoglycemia linked to increased dementia. Therefore, it is important to screen older adults for cognitive dysfunction routinely and discuss findings with the caregivers. Hypoglycemic events should be diligently monitored, and glycemic targets may need to be adjusted to accommodate the changing requirements of the older adult.[4,5]

Pharmacological Therapy

Particular care is required in prescribing and monitoring pharmacological treatment in older adults. Cost may be a significant factor, especially as older adults tend to be on many medications. Metformin may be contraindicated because of renal insufficiency or significant heart failure. Thiazolidinediones, if used at all, should be used very cautiously in those with, or at risk for, congestive heart failure and have been associated with fractures. Sulfonylureas, other insulin secretagogues, and insulin can cause hypoglycemia. Insulin use requires that patients or caregivers have good visual and motor skills and cognitive ability. GLP-1 agonists and dipeptidyl peptidase-4 inhibitors have few side effects, but their costs may be a barrier to some older patients.

A clinical trial, Saxagliptin Assessment of Vascular Outcomes Recorded in Patients with Diabetes Mellitus–Thrombolysis in Myocardial Infarction 53 (SAVOR-TIMI 53), evaluated saxagliptin (a dipeptidyl peptidase-4 inhibitor) and its impact on cardiovascular outcomes.[9] Patients treated with saxagliptin were more likely to be hospitalized for heart failure than were those given a placebo (3.5% *vs.* 2.8%, respectively, according to 2-year Kaplan-Meier estimates; hazard ratio 1.27 [95% CI 1.07"1.51]; P = 0.007).

SPECIAL CARE ISSUES FOR OLDER ADULTS WITH DIABETES

It can sometimes be difficult to differentiate between conditions that have been brought on by diabetes and those that are a normal part of the ageing process. What's more, the combination of advanced age with diabetes can lead to some unique care concerns:

Effects of High Blood Glucose

- High blood glucose levels may cause a greater need to urinate, which in turn can result in urinary incontinence, sleep disruption, dehydration and an increased risk of injuries and falls.
- Frequent urination may also be caused by certain medications, so it may be hard to determine whether high blood glucose levels or a drug side effect is the culprit. If a change in urination frequency occurs, be sure to monitor blood glucose levels carefully and talk to these elders about possible medication causes. High blood glucose levels cause the blood to become hyper-viscous and stickier, which increases the risk for stroke.[10]
- High blood glucose levels can decrease mental function and make daily diabetes management tasks difficult. Always remember that improved mental function can usually be maintained with better diabetes control.[11,12,13]
- High blood glucose levels may interfere with the immune system, increasing the risk for infection and preventing healthy wound recovery.[14]

Increased Risk of Drug Interactions and fall

- The need for a prescription and over-the-counter medications increases with age, so older individuals with diabetes have a higher risk of drug side effects and drug-to-drug interactions.
- Due to both the natural ageing process and diabetic retinopathy, poor vision can increase the risk of falls. Additionally, the fear of falling may cause an older individual to avoid social interaction and limit activities. Older adults may use pain-relieving medicines often and, as a result, suffer from reduced mental function and increased risk of injuries and falls.[10]

Changes in Eating Habits

- Changes in taste and smell, as well as stomach acid composition, are a normal part of the ageing process. This combination causes many older individuals to eat less and can bring about poor nutrition. Ageing family members with diabetes may be at higher risk for vitamin B1, B12, C, D, and folate deficiencies, in addition to deficiencies in various minerals, including calcium, zinc, and magnesium.[17]
- Older individuals with diabetes, especially those in nursing homes, tend to be underweight.[18]
- Ensure these elderly diabetic are receiving adequate nutrition as low body weight is associated with higher death rates in older adults.
- Unnecessary dietary restrictions put in place by long-term care facilities may lead to malnutrition and dehydration. If long-term care is necessary, evaluate the service for food quality and meal variety to ensure these elderly family member do not lose interest in food.
- Older individuals may not be able to tolerate a diet high in fiber. Increases in dietary fiber need to be introduced slowly in conjunction with adequate fluid intake and/or physical activity.

Diabetes Complications

It's also important to note that, due to increased age, older individuals with diabetes experience difficulties to a greater degree or at a faster rate:

- Between 25% and 70% of people aged 74 and over are estimated to have vision problems due to diabetic retinopathy. [15]
- Painful nerve damage in the legs and feet is common among people with diabetes who are over 70 years old.
- Heart disease, stroke, and diabetes-related amputations appear to occur in older adults at a higher rate. [16]
- Older adults with diabetes are 14 times more likely to suffer from depression than older adults who do not have diabetes.

What a caregiver can do

Caring for elderly with diabetes requires more than administering medication and scheduling doctors' visits. A vital role in making life as safe and comfortable as possible for elderly family member, and there is much can be done to ensuring their well-being:

- One should remain alert. Behavioral changes are robust indicators that something may be wrong with elderly member's physical or emotional health with accompanying diabetes.
- One should be extra aware of the warning signs of high and low blood glucose levels and diabetes complications in these elders.
- Always take a patient, respectful attitude when talking with older family member. Recognize that they may need more time to understand questions or learn a new routine for diabetes care.
- Choose diabetes supplies that are senior-friendly. When selecting a blood glucose meter, look for one that is easy to use, has a large display screen and does not need to be cleaned. If the elderly diabetic in the family takes insulin, consider insulin pens instead of syringes because insulin pens are usually easier and more convenient to use.
- If the elderly diabetic member lives in a nursing home or assisted living facility, review their meal plan and medication list with a staff member. Encouraging his family members unannounced visits during mealtime to see what foods are served and how well eldely is eating.
- If the elderly diabetic lives with his family member, schedule some time with a registered dietitian and diabetes educator to develop a meal plan that will not only appeal to elderly person's taste, but that will also be compatible with their diabetes care.

CONCLUSION

In old type 2 diabetes, treatment of hyperglycemia has to be integrated into global and individualized care. Geriatric assessment. In addition to avoiding fatal complications of diabetes, the prevention of decrease in the level of functional independence is the primary goal of this care and must be implemented by taking into account the type of patient, vigorous or frail. For the dependent patient, maintaining comfort becomes the priority goal. From this assessment ensure the therapeutic and glycemic goals. The choice of therapeutic tools is, a function of fixed goals, of co-morbidities, of the organization of care at home or in nursing homes, and of the iatrogenic risk, in particular, the undernutrition and the hypoglycemia.[19]

Some unique factors in diabetes Eldercare include:

- Making sure that the person receives adequate nutrition,
- Managing the person's medications to make sure they are taken properly and to prevent harmful drug interactions,
- Dealing with individual physical or mental limitations that can make it harder for the person to care for their diabetes. Caring for an older adult with diabetes may include unique challenges such as coexisting medical conditions, physical limitations and failing memory. Whether the person lives alone, with his family, or in a nursing home, everyone's involvement can help them obtain better diabetes care and quality of life.

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Status and scope of Education in Geriatric Medicine in India

*ANAND P.AMBALI

In India, the elderly constitute 9% of total population. The number of senior citizens attending out patient department and the occupation of bed rate in inpatient wards is increasing. The people who are in the age group of 50 plus now will be in geriatric category after ten years and these are the people who have insurance cover, due to which cost factor won't be a barrier .This increase in number of elderly persons will have a direct impact on the demand for health services.

In the past where the concept of family physician was strong, the senior citizens probably were happy with consultation .Present days where the days of specialization and super specialization is concept of practice, the senior citizen is facing hardship during consultation and follow up. For the senior citizens in rural areas, primary health centre has easy access for consultation. In this regard, the National Programme for the Health Care for the Elderly (NPHCE) has taken a big leap in training the health centre officers all over India regarding common problems in older people and their solutions. The author has personally being involved in training medical officers of all Primary Health Centre and Community Health Centre organised by district health authorities of Vijayapura. This included training of AYUSH medical officers too.

Definitely there is a lack of practising geriatricians in India, so is state of affair in the western countries too. The very fact that geriatric medicine as a separate system is not taught in medical colleges of India, has led to lack of awareness and knowledge about geriatric practice among clinicians.

Rasayana, in Ayurveda is a book published regarding problems in old age, long back, may be before 1500BC.

It took long time for a chapter to appear on geriatric medicine in Indian text books on Medicine. The first comprehensive text book titled Geriatric Care was published in year 2006 by Dr O P Sharma which catered to needs of the clinicians and private practitioners who were seeking knowledge about geriatric medicine.

Presently in Karnataka, only two medical colleges namely SDM , Dharwad and BLDE University ,Vijayapura conducts theory classes exclusively on geriatric medicine to undergraduates at par with other systems taught, like 20 classes in a term of six months. The author is of opinion that apart from creating consultants in geriatric medicine through courses like MD and Post Graduate Diploma in Geriatric Medicine (PGDGM), teaching and sensitizing about geriatric medicine for undergraduate students should be initiated in all medical colleges so that the students are at least made aware about common problems and their solutions in older people.

The PGDGM course conducted by IGNOU of one year is recognised in all south east countries. The doctors after completing the course should start a geriatric clinic in their place and also should be given a honorary teaching post in medical colleges so that they can teach the undergraduate students about geriatric medicine.

The World Health Organisation (WHO) strongly advocates awareness for training all future medical doctors in the care of older persons. It also promotes the adoption of a life-course approach in the education and training of doctors. WHO has developed a study on Teaching Geriatrics in Medical Education (TeGeMe) - a joint initiative of Ageing and Life Course (ALC) and the International Federation of Medical Students Associations (IFMSA) which focussed on the integration of geriatric medicine within medical curriculums worldwide.

Presently, there are many medical colleges and institutes in India who are offering certificate course, diploma course, distance learning, fellowship and masters degree in geriatric medicine. New generation doctors are slowly opting for these courses and there will definitely be a surge of geriatricians after five years. The only concern shall be of job opportunities for them in medical colleges. Government of India initiative of starting eight regional academic and research centres on geriatric medicine is on promising note and will further enhance the scope for youngsters pursuing course in Geriatric Medicine.

Medical Council of India (MCI) through its regulation in year 2012-13 has made it mandatory for all medical colleges to have a geriatric care unit. In the view of shortage of

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qualified geriatricians as on now , many medical colleges are not able to start geriatric care units. I feel may be after five to ten years, most of medical colleges shall have a geriatric clinic and a Geriatrica Care Unit. Another good thing is that the MCI has made it clear to introduce (MD) masters in geriatrics in all medical colleges even with existing infrastructure. This will boost initiation of starting courses by medical colleges.

The older people in India pose unique social, economic, and clinical challenges, including a growing demand for increasingly complex healthcare services. The students pursuing the course in geriatric medicine should not have apprehensions about opportunities. A post MBBS doctor with additional qualification in geriatric medicine when starts practicing shall be an asset to the community. Apart from his general practice, his approach to older people will be full of confidence. PGDGM courses can be persued by post MD doctors too. In fact the doctor with MD in internal Medicine when perceives PGDGM course will have more synergistic and positive approach to older people.

The geriatric medicine is a branch which has more modalities of services to offer. It includes the care of a person with multiple diseases, multiple co morbidities and disabilities. To help them out we need a multidisciplinary team of consultants from various departments like ENT, Psychiatry, Ophthalmology, Dental, OBG, Physiotherapy, Nursing and Psychology, who are easily available in medical college. To provide such a comprehensive care, a medical college hospital shall be ideal. More importantly, emergencies in older people also can be effectively dealt with in medical college intensive care units. The scope further continues to the field of preventive geriatrics too.

Certain statements are heard about the practice of geriatric medicine like it is not lucrative and most of diseases are incurable are myth. In fact the older person as a patient is a book in himself and it is a challenge for a clinician to deal with multiple problems.The knowledge translation is of paramount importance to make the older person lead a life of quality despite having multiple co morbidities and disabilities. As a part of this profession, social service and job satisfaction also need to be considered. For all this to happen a team work is required. Practicing geriatric medicine with holistic approach dispels all such myths.

The future of geriatric care lies very much in India. The medical professionals need to take up this issue to face tsunami of senior citizens in future.

The scope of practicing geriatrics is tremendous in near future. The paramedics have already initiated geriatric physiotherapy and geriatric rehabilitation centres. The orthopaedic surgeons have geriatric orthopaedic society which organises annual conferences. There are societies exclusively on diseases pertaining to older people like Alzheimer's Disease and Parkinsons Disease. The care giver training centres are initiated by Government of India in majority of state capitals which are creating trained geriatric care givers. Also the good thing is that the technology has taken a front seat in providing aids and gadgets suitable for needs of older people.

I feel, down the lane five to ten years we shall have older people approaching hospital with insurance or better financial capacity , manpower like care givers, physiotherapist and various gadgets will be available to serve older people.

The only need is passion and patience among the young generation doctors to perceive course in geriatric medicine and bring knowledge and innovative technology to serve the needs of older people and be blessed.

COPD in Elderly: Let's Rejuvenate the Ageing Lungs

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The global prevalence of physiologically defined chronic obstructive pulmonary disease in adults aged ≥40 yr is approximately 9-10%[2] and second leading cause of death. COPD is a typical disease of ageing as its prevalence dramatically increases with age. Its high prevalence in those aged more than 75 yr is about 14.2%[2] and prevalence touches 50% in heavy smokers. The age-associated increase in the prevalence of COPD suggests that changes related to ageing may contribute to COPD pathogenesis.[3]

Ageing is ongoing process that affects the structure, function, and control of the respiratory system. Both lungs and chest wall, including the respiratory muscles, bones, immune system and even nervous system undergo changes that can affect respiratory function."Senile emphysema" characterized by airspace dilatation resulting from loss of supporting tissue without alveolar wall destruction, has been described in elderly individuals without COPD. Bronchiolar diameters diminish and alveolar ducts enlarge as a result of the change in lung matrix and elastic properties of lungs. These manifest as decreased expiratory flow and surface area for gas exchange, respectively. Airways in dependent portions of the lung close at higher volumes with advancing age, so that more airways are closed during all or part of the respiratory cycle. The lower portions of the lung are better perfused at all ages, but higher closing volume with age increases ventilation perfusion mismatch (V/Q mismatch) and accounts for the declining PaO_2 (oxygen pressure) with age.[4] This causes vital capacity decline by 10–20mL/year in normal individual,[5] but about 30mL in COPD patients,[6] whereas residual volume increases in both normally ageing and COPD lung.[7]

Control of ventilation is modestly compromised, with blunted responses to hypoxemia, hypercapnia, and mechanical loading. Furthermore, ageing is a pro-inflammatory condition associated with a dysregulated immune system. Because exaggerated systemic and tissue inflammation is important in COPD pathogenesis, immunologic changes seen in COPD may overlap with those described with advancing age. Therefore, some label COPD as an "accelerated ageing phenotype" triggered by noxious stimuli like cigarette smoke.[8] Also cough strength is decreased in the elderly population due to anatomic changes and muscle atrophy alterations in the muscles that aid respiration.

DIFFICULTIES IN DIAGNOSIS OF DISEASE

Two main early symptoms of COPD are Breathlessness on exertion and Cough with expectoration sometimes accompanied by wheeze.

Many times COPD is complicated by chronic respiratory failure. Unfortunately, most cases remain undiagnosed because most elderly restrict their physical activity well below the dyspnea level & may consider dyspnea as age related factor.Atypical clinical presentations are most important factors for misdiagnosis or underdiagnosis. Even severe exacerbations of COPD can be recognized late due to atypical presentation. Indeed, at variance with the classical triad of dyspnea, cough and fever,[9] muscle weakness, vertigo, confusion and leg oedema, all reflecting severe hypoxemia, are the hallmark of atypical presentations.[10]

Spirometry plays a pivotal role in the diagnostic workup,[11] The spirometric criterion for airflow limitation remains a post-bronchodilator fixed ratio of FEV1 /FVC < 0.70 which confirms the presence of persistent airflow limitation and thus of COPD.[12] But this fixed criterion may cause misdiagnosis as frail and disabled people may not be able to satisfactorily perform this test. This is due to difficulty in coordination and properly sequencing the flow volume manoeuvre and the breath holding. In an attempt at expanding the number of elderly people having a diagnostic spirometry, FEV6, (i.e., the maximum volume of air expired at any time before the 6 seconds of the forced expiratory manoeuvre) has been introduced and repeatedly tested. If the patient is unable to reach an end expiratory plateau ≥1 s, forced vital capacity (FVC) is not measurable, while FEV6 is. Accordingly, FEV1/FEV6 can substitute for FEV1/FVC particularly in elderly. FEV6 has been proved to have good diagnostic properties for both obstructive and restrictive respiratory diseases.[13] It also identifies smokers at risk of faster respiratory decline.[14] Other

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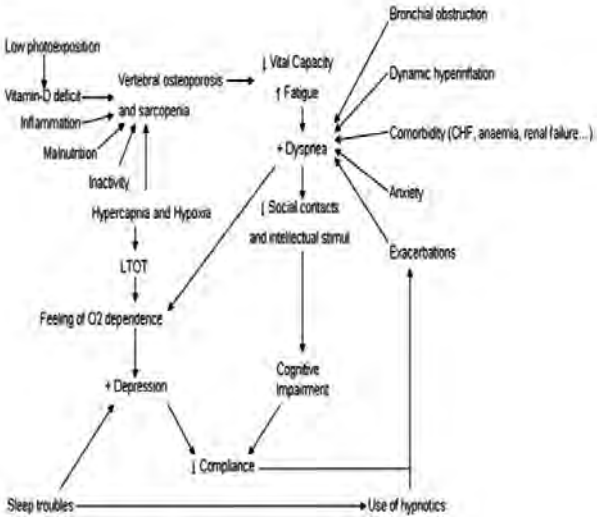

Figure1: *Synopsis of factors conditioning health status in elderly COPD patients.*

factors which effect spirometry tests are mood depression and psychological factors, educational level, Malnutrition/ undernutrition, deconditioning.

CO-MORBIDITIES AND COPD

Co-morbidities add to the individual severity of the disease, which interncontributes to increased morbidity, quality of life & mortality in elderly COPD patients.

The overall prognosis of COPD is poor. The 3-year mortality in a COPD population without respiratory failure or other serious disease has been reported to be 23%.[15] Co-morbidity like Lung cancer, osteoporosis, depression, anxiety, metabolic disorder, cardiac failure is a major prognostic factor in elderly COPD patients.

Table 1: Established & probable risk factors for COPD.

Established	Probable risk factors for COPD
Tobacco smoking	Outdoor air pollution
Exposure to biomass fuel smoke	Pulmonary tuberculosis
Occupational exposure	Poorly treated asthma
Alpha-1 antitrypsin deficiency	Repeated lower respiratory infections during childhood
	Others: Age, gender, low socioeconomic status

To evaluate severity, co-morbidities, alternative diagnosis in COPD some other tests like chest x-ray, ECG, pulse oxymetry, ABGA, DLCO, 6MWT, sputum for gram stain, blood sugar and biochemical test are need to be done.

DIFFICULTIES IN TREATMENT OF ELDERLY COPD

The goals of COPD management are to reduce individual patient's symptoms including disabling dyspnea and comorbid conditions, decrease in long-term function decline, preventing of future exacerbations, reduce hospitalizations and mortality, and improve exercise tolerance. In elderly patients, these goals are difficult to achieve and the treatment should be individualized to maintain an acceptable level of health-related quality of life. It is the result of a compromise between therapeutic needs and individual limitations.

Treatment components include pharmacological & non-pharmacological management. Pharmacological management includes treatment of disease itself mainly by inhaled bronchodilators like long-acting β_2 agonists and anticholinergics. These are the mainstay of pharmacologic therapy. The ideal management of COPD at any age is the inhalation therapy, since inhalation route allows a rapid

Table 2: Comorbid conditions affecting COPD

Con-causal: sharing risk factors, mainly smoke	Coexisting in the absence of shared risk factors, except for age	Complicating COPD
Atherosclerotic disease:coronary, cerebral, lower limbs	Glaucoma	Anxiety/depression
Chronic renal failure	Cognitive impairment	Cognitive impairment
Lung cancer	Diabetes mellitus	Osteoporosis
Congestive heart failure	Benign prostatic hypertrophy	Sarcopenia
Aortic aneurysm	Degenerative joint disease	Arrhytmias
Bladder cancer	Hypertension	Dysphagia
Pulmonary fibrosis (respiratory bronchiolitis– interstitial lung disease)	Obstructive sleep apnea	Pulmonary embolism

achievement of therapeutic effect and significantly less side effects.[16, 17] The most common devices used for the inhalation therapy are metered dose inhalers (MDIs). In elderly, real difficulties in using this devices are due to the presence of hands arthritis, muscle weakness, poor dexterity, visual impairment, poor coordination between actuation and breath or absence of apnea after inhalation.[18] Methylxanthines could be an adjunct to first line therapy if symptoms persist or if patients have trouble using inhaler devices.[19]

Non-pharmacological management includes smoking cessation & pulmonary rehabilitation. Smoking cessation is the intervention with the greatest capacity to influence the natural history of COPD. Repeated rehabilitation can dramatically slow the decline of health status and decrease the need of health care as well as improve COPD-related mood disorders.[20]

Cardiac comorbidity like congestive cardiac failure (CCF), arrhythmias & hypertension are commonly present with COPD &both have similar clinical presentation. Serum BNP levels have significant role in evaluation of COPD & CCF. If S. BNP <100pg /ml it is less likely CCF, >500pg /ml suggestive of CCF while 100-500pg /ml indicates right heart failure, moderate left heart failure or both. In cardiac condition pO_2 is reduced & pCO_2 will be in normal range but in COPD $pO_2$is reduced & pCO_2 is raised.

Elderly COPD patients are exposed to an important risk of adverse drug reactions due to overdosage of drugs with renal clearance. Indeed, sarcopenia, a common trait of severe COPD, blunts the creatinine rise due to depressed glomerular filtration rate. Thus,moderate (GFR= 60–30) and even severe renal failure may remain unrecognized. This problem can emerge in the occasion of acute exacerbation requiring antibiotics or chronically for non-respiratory drugs and also for some topical bronchodilators which are fractionally adsorbed and cleared by the kidney.

Hypercatabolism and accelerated loss of muscle mass characterize severe exacerbations of COPD, but they also are a sort of phenotypic trait of an important fraction of COPD patients. Thus, attempts at treating promptly the exacerbation, so that the inflammatory response ceases, and providing nutritional support and rehabilitation are key issues in the treatment of exacerbated COPD.

In advance COPD with resting ABGA PO_2<55 mmHg OR/ & Spo2 <88%& PO_2 55-59 mmHg OR/& Spo2 88-89% with polycythaemia, cardiac failure, pulmonary hypertension are indication for Long term Oxygen Therapy (LTOT) >15hrs/ day should be considered in appropriate patients. It is big challenge for elderly patients to handle portable oxygen supply in daily routine activities.

Immunization is given to elderly COPD patient to reduce future exacerbations and risk of infection. Pneumococcal and influenza vaccines are considered. Pneumococcal vaccine is given as single shot intramuscular in patient with >65yrs old, while influenza, vaccine given on yearly basis.

Managing mental health problems associated with COPD should be an important part of the management plan for the short term as well as the discharge, including the recognition of mental health as a potentially modifiable target to reduce COPD-related readmissions.[21]

In extreme cases, lung volume reduction surgery & lung transplantation can be considered.However, surgical management is seldom preferred in elderly due to high peri-operative morbidity & mortality and cost effectiveness.

Elderly with COPD are requiring dedicated care to minimize her/his sufferance (suffering) and to help relatives and caregivers. Unfortunately, palliative care for the respiratory patient is poorly available and less perceived as an important health need.[24] Shared decision making with patient & care provider, regarding palliative therapy & end of life care are according to patient's wishes & goal.

CONCLUSION

COPD is a "blanket" definition for a very heterogeneous disease. Older age adds to this heterogeneity mainly in terms of atypical presentation, confounding by co- morbidity and poor knowledge of age-related changes in responsiveness to therapy proved useful in adult populations. The goals of treatment of COPD in the elderly include prevention and treatment of symptoms, maintaining an acceptable level of physical activity and improving lung functionality with minimal side effects from the medication used. In the long term, the main objective is to reduce decline in lung function and mortality. Progress in the treatment of obstructive airway diseases increased life expectancy of these patients, extending the interval between onset and death. These patients survive for a longer period despite deteriorating respiratory function, having an important impact on health services due to the significant increase in the number of elderly patients with COPD.

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GSICON 2016 New Delhi
10 & 11 December, 2016.
Scientific papers presentation Schedule

Scientific Papers for Platform Presentation		7 mins presentation +3 mins Discussion.	
Group A	Group B	Group C	Group D
Cardiology/ Musculoskeletal/ Clinical Geriatrics	Pulmonology /Neurology	Behaviour Sciences	Sociology
A1-Linkage of haemoglobin with stress, blood pressure and muscular strength among adults of Delhi. Ms. Meenal Dhall	B1-COPD - Dr. Eshan Hemant Shinde	C1-Financial Fitness for Worry Free Active Ageing Ms. Shweta Rai	D1- Sallekhana – Philosophy of Death Dr. Mahaveer Mithari
A2-Cardiovascular health and its association with adiposity markers and blood sugar in urban population. Ms. Renu Tyagi	B2-ECG and ECHO changes in acute stroke and its prognostic significance Ms. Parimala Pydi	C2-Assessment of Spiritual Needs of the Elderly Persons Climbing the Seven Hills of Tirumala on Foot for Darshan of Balaji. Ms. Lavanyakumari G C	D2-A Cross sectional Study of Social and Medical Problems of Elderly Persons living in an Old age home at Tirupati in Andhra Pradesh Ms. Tejaswini G
A3-A Clinical Study of Hypertensive Emergencies in Elderly patients in a Tertiary Care Hospital Ms. Dilshad Begum N	B3-Care of Geriatric patients with Hemiplegia . Ms. V.Ujjwala	C3-Reflection of an Emergency Resident towards the Geriatric Patient Mr. Ramyakumar M	D3-Role of support staff in the care of the elderly. Ms. Kiran V
A4-Integrated Falls Prevention: An enabler to Active Ageing. Ms. Mateen Ansari	B4- A Study of correlates of depression in elderly population of rural Haryana. Dr. Neelam Kumar	C4-Profile of Unknown Geriatric Patients Admitted in a Tertiary Care Hospital Ms. Saraswatii B	D4-Perception of Tenth Class Students on Elderly Mr. Madhusudana Pulaganti
A5-Disease profile and outcome of Geriatric patients admitted in the department of General Medicine in SVRR Government General hospital, Tirupati. Ms Divya Latha	Judges – 10/12/2016 1. 2.	C5-CHILD to 'OLDIES' programme – An experience from Tirupati . Ms. Kireeti A S	Judges – 11/12/2016 1. 2.
A6-Profile of elderly persons attending Village Health Clinic and its potential for teaching-learning Mr. Janardhana Raju B	Date – 10/12/2016 Time –02.00PM to 04.00PM Papers - A1 to A4, B1 & B2, C1 & C2, D1 & D2. Venue -	Date – 11/12/2016 Time – 12.00PM to 02.00PM Papers – A5 & A6, B3 &B4, C3 to C5, D3 & D4. Venue-	Dr Anand P.Ambali Chief Coordinator Free Papers 09845821477

Frailty Syndrome

*P.S. SHANKAR

INTRODUCTION

Elderly persons can become frail. Frailty refers to a condition in which a person exhibits diminished ability to undertake essential social activities of daily living under minor environmental stressful situations. There is a diminished reserve in the physiological function of different organ-systems of the body to carry out important daily activities and to maintain adequate homeostasis. Thus frailty is a progressive physiological decline in multiple organ systems marked by loss of function, loss of physiological reserve and increased vulnerability to disease and death.[1]

Frailty is a clinical syndrome associated with increased risk of functional disability, and is a dynamic process. It is common in older adults and in those with multiple co-morbidities. The condition may be encountered independently thus differing from ageing.[2]

FRAILTY AND DISABILITY

Though frailty has been considered a form of pre-disability, the term should not be confused or mistaken with another entity called, disability. Disability may develop from a single pathological event leading to actual loss of function. Frailty develops from multiple pathologies and there is an increased vulnerability to loss of function.

They are separate entities. Disability refers to an established loss of function following a condition such as stroke, poliomyelitis or fracture. The situation may develop from a single pathological event in otherwise healthy individual. The person remains stable after recovery without much fluctuation in function. The person generally remains in good health. In frailty there is an increased vulnerability to loss of function, and the individuals are unable to withstand minor environmental stresses of daily life. There is a marked fluctuation in response to any minor illness. Frailty and disability can coexist.

DOMAINS IN FRAILTY

Frailty is a complex disorder that occurs during the ageing process. The frail person exhibits impaired function in different specific domains (Table 1). Each domain is assessed while making a comprehensive assessment of frailty. These examinations in different domains are necessary before applying the term 'frail' to an individual. It must be noted that not all old persons are frail.

Till recently, diagnosis of frailty was mostly subjective, now objective methods for its diagnosis have been formulated. It was thought frailty is an inevitable part of old age, now it is considered as an avoidable condition. There is impairment of musculoskeletal function and poor nutritional status.

The objective criteria for the diagnosis of frailty have been formulated by Linda Fried and her colleagues (Table 2).[3] Frailty is defined as having any 3 of the 5 attributes.

There are altered biological processes in the frail subset of older adults. Frailty is both a physiologic and a biologic syndrome separate from normal ageing process and from disability. Ageing is far riskier for people who are frail. The biology of frailty appears to be independent of age and specific disease states.

AETIOPATHOLOGY

The development of frailty is influenced by genes, environment and life style. The persons with frailty exhibit an excess loss of functional muscle. There is some deterioration in executive function.

Many different body systems become dys-regulated on an anatomic, molecular and physiologic level as people reach old age. Some of these systemic changes are more quickly noticeable in people who are frail. The studies have linked frailty to an increase in inflammation and blood clotting activity. There is a decline in humoral and cell-mediated immunity with advancing age. There is over expression of cytokines, decline in the level of hormones, loss of muscle mass and muscle strength or sarcopaenia.

It has been postulated that some changes are responsible for frailty (Table 3).[4]

The interaction of age-related physiologic deterioration and different disease processes such as anaemia, congestive heart failure, chronic obstructive pulmonary disease (COPD), conditions that interfere with muscle function such as diabetes mellitus, peripheral vascular disease, *polymyalgia rheumatica*, and pain by limiting the capacity to undertake exercise result in the development of frailty (Table 4).

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Table 1: Impaired domains in frailty

Musculoskeletal function
Cardio-respiratory function
Cognitive function
Neurological function
Nutritional status

Table 2: Criteria for the diagnosis of frailty

1. Unintentional weight loss of more than 4 kg in one year
2. Physical exhaustion by self report
3. Muscle weakness as measured by grip strength
4. Decline in walking speed
5. Low physical activity

SARCOPAENIA

Persons with frailty exhibit loss of functional muscle. Sarcopaenia (Gk. *Sarx*-flesh; *penia*-loss) is age-related loss of muscle mass that is responsible for the decline in muscle strength. It forms the main factor in the pathogenesis of frailty.[5] Elderly persons with sarcopaenia, exhibit decreased lean body mass and muscle strength. Ageing is associated with a marked uncoupling of muscle cross-sectional area and muscle fibre strength. There is also accumulation of fat in the muscle (myosteatosis). Myosteatosis refers to accumulation of fat in muscle and it causes a decline in muscle strength leading to functional impairment and physical disability bringing about changes in gait and balance.[6]

Many frail persons show certain amount of weight loss. This is due to the play of multiple factors in elderly persons that include sarcopaenia, anorexia, dehydration, wasting, depression, disease states such as tuberculosis, cancer, congestive heart failure, COPD, chronic renal failure, and hip fracture, dietary restriction and side effects of medication. Efforts are to be made to improve the nutrition status in the elderly to protect from effects of frailty.

CLINICAL FEATURES

The patient presents with a variety of vague complaints and narrates them very slowly. The clinical presentation is often atypical and they appear quite late. Often there are multiple co-morbid associated conditions. Frail elderly patients exhibit symptoms such as weight loss, weakness, fatigue, slow walking speed, and low physical activity.[7] These manifestations interact with each other and lead to a fall in physiologic reserves. Some of these features are related to the loss of muscle mass and muscle strength.

The patients often present with falls and unsteadiness. Many illnesses present with falls, confusion or incontinence rather than more specific signs and symptoms. These individuals often exhibit reduced perception of pain and are febrile.

Table 3: Changes responsible for frailty

1. Increase in age-related free radical production and resulting DNA damage
2. Shortening of telomere
3. Changes in gene expression
4. Cellular senescence

Table 4: Conditions producing frailty

Pain limiting the ability to exercise
Disease limiting cardiopulmonary function
Disease interfering with muscle function
Weight loss
Impaired executive function (depression, cognitive deterioration)

FALL

Unsteadiness and falls are commonly encountered in older especially frail persons. Though not all fall results in fractures or serious injury, the occurrence of fractured neck of femur is the most dreaded situation.

CLINICAL ASSESSMENT

The history should give information on the mode of onset of the complaints and their speed of progress, medication, details of the daily activity and ability to perform them, walking and occurrence of confusion. The clinical examination should include gait, balance and stamina, nutrition, vision and hearing and mental state including cognitive function. All systems are to be examined in detail to identify the abnormality.

A comprehensive assessment of the patient has to be made with a detailed, slowly elicited history, and a thorough physical examination. Frailty may exhibit the following features: 1) weight loss of 4.5 kg or more during past implying poor nutritional status, catabolic metabolism and sarcopaenia, 2) poor endurance presenting with a feeling of exhaustion, 3) weakness as demonstrated by poor grip strength, 4) slow walking with short steps, and 5) decreased physical activity. The cognitive function, gait, balance, hearing capacity and nutrition and ability to perform daily normal tasks are to be assessed. The findings help in planning the regimen to deal with acute problem and to improve overall health and function, with an aim to reduce the likelihood of recurrence of subsequent illness and improve the quality of life. The presence of co-morbidities is to be recognized.

TREATMENT

No specific treatment for frailty is available. The treatment of elderly persons who are frail involves the treatment of the precipitating acute illness and the underlying loss of function.

There is also need to prevent any further loss of functions by early intervention. After treating the precipitating event, a multi-pronged approach in the management is necessary to improve the musculoskeletal function, and balance. Nutritional support is necessary to restore lost weight. Thus two factors such as physical activity and diet are readily modifiable. Pharmacological intervention is also undertaken, though the benefits from such interventions are less evident.

Exercises are necessary to improve flexibility, strength and balance. Inactivity forms an important factor contributing to the loss of muscle mass and strength. Immobilisation induces anabolic resistance, skeletal muscle apoptosis, sarcopaenia and frailty at old age.[8,9] Physical exercise strengthens the muscles and also reduces levels of inflammatory factors and increase in IGF levels to a small degree. Exercise is one of the important factors in therapy that can help in stopping frailty. Resistance or weight training is an effective counter measure to sarcopaenia, decline of muscle mass and muscle strength. Such exercises are able to bring about an increased muscle cross sectional area (CSA). Resistance exercise training increases mixed muscle protein synthesis rate in frail individuals.[10] Muscle strength increases after a few days of training, whereas muscle mass increases after 6 to 8 weeks of resistance training.[11] It must be noted that the aerobic activity such as walking, running, cycling or jogging has not much effect on augmenting muscle mass and strength.[12]

Sarcopaenia that leads to frailty and functional impairment can be improved with resistance exercise. ACE inhibitors may retard the loss of muscle strength in some individuals.[13] A reduction in the level of testosterone with ageing is associated with the loss of muscle mass, strength and functional decline. Testosterone replacement may stimulate protein synthesis in hypogonadal men. There is a moderate increase in muscle strength among men.[14] However indiscriminate administration of testosterone in frail older individuals may have an increased risk of cardiovascular adverse effects.

Decreased food intake especially protein leads to weight loss and decreased muscle mass. It aggravates frailty. Often there is anorexia. Loss of muscle mass occurs from an imbalance between protein degradation and synthesis rates. The elderly individuals need an increased dietary protein and amino acid.[15] Leucine, an essential amino acid stimulates muscle protein anabolism in healthy elderly adults.[16] In the background of this administration of proteins rich in leucine is likely to prevent sarcopaenia.[17] Adequate food intake, protein supplementation and supplemental creatine, and vitamin D help in maintenance of muscle quality. Creatine supplementation may be beneficial in the management of sarcopaenia.[18] However it has not demonstrated any increase in lean mass.[40]

PREVENTION

There is no specific modality of treatment for frailty. Since multiple pathways are involved in the development of sarcopaenia that has a key role in the development of frailty, the trials have shown that the condition can be prevented by muscle strengthening exercises, healthy diet, adequate amount of sleep, administration of hormones and growth factors, and lifestyle interventions. There is need to reduce the number of drugs taken, to train balance and gait, to correct postural hypotension by rationalizing medication, adequate hydration and use of non-steroidal anti-inflammatory drugs that cause salt and water retention, thus increasing the circulating volume, and to direct attention to those factors to reduce risk of falls[19]

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Influenza from an International Perspective

*A.M. PALACHE

The disease- and economic burden of influenza is well documented.[1,2] Health Authorities and international institutions such as WHO recommend annual influenza immunization to prevent the disease and its complications for patients at risk of serious complications due to influenza infections. Particularly, patients with underlying medical conditions, such as diseases of the respiratory tract, vascular and heart disease and diabetes, have an increased risk of serious complications associated with their underlying medical condition. But also, young children who have not been exposed earlier to influenza viruses are at increased risk of serious complications following influenza infections at this early stage of their life.

The safety and benefits of available seasonal influenza vaccines are well established.[3] Scientific evidence[4-6] supports the recommendations by Health Authorities and WHO and hence, in many countries immunization programs and efforts are in place to ensure implementation of these recommendations. However, surveillance of global seasonal influenza vaccine distribution data shows serious unequal distribution of vaccines, as a proxy of their disparate usage, around the globe.[7] The majority of vaccines are distributed in the Americas, Europe, Japan, and Australia, whereas in South East Asia the use of seasonal influenza vaccines is very low in most of the countries. Even in regions with substantial vaccine distribution and usage, vaccine uptake rates in many countries remain low.

The disparity of influenza vaccine distribution around the globe poses a serious public health problem. With an ageing global population, there will be an increasing pressure on public health budgets and ways to reduce health costs will be required. Disease prevention, including influenza associated disease, is an important option to reduce health costs.

For example, influenza has been identified as a primary cause of 2%-3% of deaths due to cardiovascular disease.[8,9] Acute lower respiratory tract infections have been associated with an up to 5 times transient increase in the risk of a vascular event.[10] Meta-analysis of influenza vaccine effectiveness showed reduction of the risk of cardiac events in patients with established cardiovascular disease.[11,12]

Improved influenza immunization would therefore contribute to the "25 by 25" goals of the World Heart Federation as formulated in the "Mexico Declaration" in June 2016.[13]

The cost-effectiveness of influenza vaccination is well documented. Implementing currently existing immunization policies and recommendations offers an immediate benefit for patients and societies.

In addition to the benefits of immunization for both at-risk individuals (to reduce the chance of serious influenza illness and complications) and for society (by secondary prevention of heart disease and reduction of costs associated with influenza-triggered disease and complications), compliance of influenza prevention policies offers the opportunity to counter the serious emerging public health problem of increasing antimicrobial resistance. First, fully implemented influenza immunization programs will reduce the number of infections to be treated. Second, it will reduce the often inappropriate use of antibiotics for influenza infections. Antibiotics are exclusively effective to treat bacterial infections, but not effective against viral infections, such as influenza. Thus, by increasing the use of influenza vaccines globally, the need for antibiotic use will be reduced as well. Because of:

1) the huge annual burden of influenza for many patients at-risk including children below 2 years of age, patients with respiratory and cardiac underlying conditions and the elderly,

2) the availability of safe and effective influenza vaccines,

3) the prevention of secondary myocardial infarction by influenza immunization

4) the existing policy recommendations and guidelines for influenza prevention by Health Authorities and WHO

5) the emergence of the antimicrobial resistance Public Health threat and

6) the ageing global population,

There is an urgent Public Health need to fully implement influenza prevention policy guidelines in each part of the world. It does not seem reasonable to accept the considerable global disparity of seasonal influenza vaccine distribution much longer.

It is in the best interest of individuals at risk, as well as societies, to optimize the use of influenza vaccines as

*IFPMA Influenza Vaccine Supply International Task Force

preventive measure to reduce the annual disease burden associated with seasonal influenza and, by doing so, contribute to a reduced usage of antibiotics.

In regions and countries with low influenza vaccine distribution rates, it is strongly advised to develop and implement regional, national and local strategies to increase influenza immunization rates.

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Abstracts GSICON 2016

Sallekhana – Philosophy of Death

Dr. Mahaveer Mithari

Introduction: Death fear among elders have been conceptualized in a variety of ways as unitary, as a continuum ranging from a negative feeling of fear to a positive feeling of joy. Death is inevitable and many religions of this world have thought over the problem of facing death, what physical, psychological, intellectual and ethical preparations should be made to welcome Death and life after Death.

But in Jain philosophy there is a religious philosophical approach to Death known as *Sallekhana*. It is a system evolved to welcome Death with mental equipoise, gradually purifying mind, shedding passions, ruining Karmic bondage and weakening of the body through regulated diet and fasting.

The purpose of this study is to study the concept of *Sallekhana* and bring social attitude among geriatric population towards death through it. Instead of feeling neglected and humiliated at death time of elders by the family members and community it celebrates like as a Mahotsva in Jain community, which is a great social and religious activity.

Objectives:

1. To study the concept of *Sallekhana* and to discuss it's social attitude.

2. To bring awareness about *Sallekhana* in geriatric population to treat death as religious activity.

Material and Methods:

The present study was conducted in Gangavesh area of Kolhapur city Maharashtra state of India among geriatric population with age greater than 60 years. The elderly persons were interviewed with questionnaire to know their social status and knowledge regarding *Sallekhana* . A pilot study was conducted where 25 elderly persons reported their very poor knowledge about *Sallekhana*. Then the awareness was created through different extension methods among selected population and their knowledge was noted before and after the programme. The data was entered in MS Excel and analyzed using the latest SPSS.

Results:

The elderly respondents mentioned that *Sallekhana* is a religious philosophical approach to death and it is a way of life in Death. Most of them noted that due to better understanding of the *Sallekhana* they changed their way of thinking towards death. Out of total 100 elders, 70 per cent showed positive attitude towards *Sallekhana* and reported that such type of death will be very peaceful one. They also told that death is an inescapable unpleasant fact that is very near to them now. But through *Sallekhana* it is treated as Mahotsva with vital support of family members and also avoids isolation, penury and misery at the last movement of life.

Conclusion: *Sallekhana* is initiated to the person in the case of whom the death is eminent such a person can control his passions like aversion, hate, love towards wordly things and relatives. The social impact is very effective because the person initiated into *Sallekhana* leaves his material things to needy people, which is the non-possession principal, observed in this concept.

After all principal of non-violence, non-possession, mental satisfaction and social unity are created by observing *Sallekhana*, which is very urgent need of today's modern life.

C.E.O. India Home Care Medicine, Kolhapur, Consultant Family Physician.

COPD Case

Dr Eshan Hemant Shinde

A 45yr old female Mrs Deepti Pandit, retired teacher came to the O.P.D. with chief complaints of swelling over the abdomen since 15 days generalized weakness since 15 days

Weight loss of 15 kgs in the last 45 days.

Loss of appetite since last 6 months

Patient was alright 45 days back since when her symptoms gradually progressed

Patient noticed swelling over the left side of abdomen which was hard and non tender

Her routine lab investigation reports were:

Hb - 8.2

TLC – 3,600

Plt - 60,000

PBS – Microcytic hypochromic

USG abdomen suggestive of massive splenomegaly, 21 cm. Hepatomegaly, 17cm.

Clinical Course

Patient was admitted to the female ward for 45 days. Further investigations,

LFT – ENL

RFT- WNL LDH – 360

ANA- 0.32 Sickling test- neg

Direct Coomb's test- neg

Osmotic fragility- normal

Lymph node biopsy- inconclusive

HRCT thorax- normal study

Bone Marrow biopsy- ?Lymphoma ? Non Hodgkin's lymphoma

CD3 – negative CD20- diffusely positive

Hematology ref – Patient was asked to get a PET Scan done, and immunohistochemistry CD20 and CD5 from the private lab and review back. Patient yet to follow up, planned to enroll for further treatment.

Mailing Address- DY Patil Medical College, Pimpri, Pune

Linkage of haemoglobin with stress, blood pressure and muscular strength among adults of Delhi

Meenal Dhall

Anemia is a non-infectious disorder rising mainly due to deficiency of iron in dietary intake. The main aim of the present study was to evaluate the association of haemoglobin level with blood pressure and muscular strength among adults of Delhi. Total 172 adults were assessed belonging to the age group from 18-45 years. Anemia was defined according to World Health Organization's standards. Hemoglobinometer was used for measuring the hemoglobin concentration in blood using single prick. Canadian Mental Health Association Stress questionnaire was used to assess stress level for the present study. JNC VII cut off was used for blood pressure classification. Muscular strength was taken using hand dynamometer. Mean, standard deviation t-test of significance and correlation was used for statistical analysis using SPSS 16.0.

The results showed that hemoglobin level is positively associated with muscular strength, systolic and diastolic blood pressures and negatively associated with stress level. The study concludes that by adopting an active life style, hemoglobin level can be improved as it plays an important role in the individual's health which is preventable.

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Cardiovascular health and its association with adiposity markers and blood sugar in urban population

Renu Tyagi

The present paper aims to study the association of blood pressure with adiposity markers, fat percent and Random blood sugar (RBS) among females staying in urban Delhi. A cross-sectional study among 245 women of age 20 to 75 years (Mean age 46 years) was conducted. Blood pressure, Random blood sugar level, fat percentage using bio-electric impedance technique and adiposity indices such as body mass index (BMI), waist–hip ratio (WHR), Grand Mean Thickness (GMT) and waist–height ratio (WHtR) were taken. Mean, standard deviation, and ANOVA were used to analyze the data. Statistically significant differences were obtained among normal, prehypertensive and hypertensive women. Both general and regional adiposity showed significant association ($p<0.001$) with systolic and diastolic blood pressure. Random blood sugar level also showed significant and positive association ($p <0.01$) with blood pressure. Prevalence of hypertension among women, increased with an increasing BMI, GMT, WHtR, WHR and fat percentage. Adequate awareness, prevention and management of obesity and hypertension is essential in present scenario.

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A Clinical Study of Hypertensive Emergencies in Elderly patients in a Tertiary Care Hospital

Dilshad Begum N[1], Ch Indira Priyadarsini[2], Imroz, S M[3], Sridhar M S[4]

Abstract category: Neurology

Preferred mode of presentation:Platform presentation

Abstract:

Background: Hypertension affects individuals of all classes and across all age groups. Although great strides have been made in the treatment of hypertension, patients still present in hypertensive crisis and emergencies. They account for more than 1/4th of medical urgencies and emergencies.The present study was undertaken to study the etiology, risk factors, clinical presentation in elderly patients with hypertensive emergencies in Sri Venkateswara Ramnarain Ruia Government General Hospital, Tirupati.

Objectives : 1. To describe the modes of presentation and clinical profile of patients with hypertensive emergencies in Sri Venkateswara Ramnarain Ruia Government General Hospital, Tirupati.

2. To describe the target organ damage in patients with hypertensive emergencies.

Methods:

Study design: A hospital based prospective observational study

Study subjects: Patients admitted in acute medical care and medical wards with hypertensive emergencies during a

study period of one year in Sri Venkateswara Ramnarain Ruia Government General Hospital, Tirupati. Informed written consent was taken from the patient or his/her attenders.

Sample size: Fifty patients who met the inclusion and exclusion criteria were included in the study.

Inclusion criteria:

1. Patients above 60 years of age.
2. Systolic blood pressure of ≥140 mm of Hg or diastolic blood pressure of ≥90mm of Hg[2].
3. Evidence of target organ damage either clinically or on laboratory findings

Exclusion criteria:

1. Chronic renal failure and valvular heart diseases.
2. Pre-existing neurological deficits,intracranial space occupying lesions.
3. Diabetes mellitus, hyperthyroidism.
4. Prolonged use of corticosteroids.

Results: Thirty five out of 50 patients in the study group are male, 60% are between 60-69 years age, 40% from 70 years and above, neurological deficits (50%) are most common presentation followed by breathlessness (35%), chest pain (30%), convulsions (5%), loss of vision (5%), 40% are known hypertensives and out of them 73% on medication; 27% of noncompliance is seen. LV dysfunction was seen in 60%. Case Fatality rate was 30 per cent.

Conclusions: Hypertensive emergencies are common after sixth decade. Males and those already diagnosed to have hypertension are at high risk. In-hospital mortality rate is 30 per cent.

Disease profile and outcome of Geriatric patients admitted in the department of General Medicine in SVRR Government General hospital, Tirupati

Divya Latha Y[1], Ramadevi M[2], Jaya Bhaskar C[3]. Sridhar M S[4]

Background: The elderly age groups > 60 years are the most vulnerable and high risk groups in terms of ill health and consequent health seeking behaviour. The present study was undertaken with objectives to determine the disease profile and outcome of geriatric patients admitted in the department of General Medicine in SVRR Government General Hospital, Tirupati.

Methods: hospital based retrospective study, from 1st January 2016 to 30th June, 2016 of geriatric age group (≥60years) admitted in Medicine Service in SVRR Government General Hospital, SV Medical college, Tirupati.

Results: Of the 3140 patients admitted in Medicine Service 1242 (39.6%) patients were in geriatric age group, 36% were females; most common age group affected was 60-65 years. Mortality was 13%; majority of the deaths were in Acute Medical Care Unit. Hypertension and cerebrovascular accidents remain the main cause for admission (35%). Sepsis and infections are the major reason for mortality (23%).

Conclusion: Hypertension followed by cerebrovascular accidents accounted for most of the patients; chronic renal disease, chronic obstructive pulmonary disease, ischemic cardiac disease and endocrine diseases like diabetes are the other important conditions. As most admissions are in acute medical care, focus should be placed on the geriatric clinics, proper education regarding disease, drug usage and the need to follow up.

1.Post graduate in General Medicine 2. Assistant Professor of General Medicine,3. Professor of General Medicine, Professor of General Medicine and Principal, SV Medical College, Tirupati

'Profile of elderly persons attending Village Health Clinic and its potential for teaching-learning'

Janardhana Raju B[1], Shankar Reddy D[2], MS Madhuri[3], Bharadwaj Pegatraju Krishna[4] , M.S.Sridhar[5]

Introduction: Training in MBBS Course is to be conducted in OPD, In-patient and Communty settings. Apart from the compulsory rural postings, organizing health camps in village setting on voluntary basis provides scope for inculcating organizational abilities and leadership qualities among the students. Following the experience of clinics conducted by Residents in General Medicine earlier, weekly clinics were planned and conducted so that members of NSS, Rotaract Club, Leo Club, NMO branch and Junior Red Cross could conduct clinics under guidance of a Faculty member. In practice from April, 2015 to May, 2016, 28 such clinics were conducted which accounts for a clinic per fortnight. The profile of elderly attending the clinic by ICD coding is reported.

Objective: To report the experience of a learning activity in the community for MBBS students

Design: Action cum Research activity.

Method: Record analysis of the weekly clinic conducted.

Results: During the period of study 325 person visits to the clinic are documented of which 54 visits were by persons aged 60 years and above. 19 Men and 45 women visits were documented. Thus, 16.6 per cent of visits were by elderly persons. On average 12 persons attended each clinic. The main ICD coding for the the elderly were E11, E15, I11, I15,

J04, J45, K27, L89, M01 and M24. Home visits were also made.

Conclusion:

This project provided experiential learning to students in natural home and community setting. The response of students was lukewarm and motivational discussions are needed to promote this type of learning.

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Financial Fitness for Worry Free Active Ageing

Ms. Mateen Ansari[1], Ms. Shweta Rai[CFP2]

Active ageing is about enabling a positive relationship between activity and life satisfaction. WHO defined active ageing as "the process of optimising the opportunities for health, life long learning, participation and security in order to enhance quality of life as individuals age". Active ageing strategies are formulated to motivate older people to have regular participation in meaningful activities and social relations. Increase in life expectancy must be associated with high life satisfaction despite common age-related disabilities and chronic conditions and a sustained increment in social and emotional wellbeing. With longer life spans it is seen that ageing adults outlive their finances, which threaten such productive ageing strategies. Meeting this existential need forms the crux of successful ageing. Hence a firm foundation of financial security and financial independence in older people is mandatory for success of such active ageing strategies and to maximize engagement, return on active ageing investment and enhanced quality of living. Personalized and structured Financial Fitness helps maximize opportunities of active ageing with a comfortable retirement nest regardless of age and time. Financial Fitness assessment and planned monitoring is to enjoy good quality of life today while preparing financially for critical transitions while ageing or in the continuum of life. The emphasis in older people is not entirely towards generating wealth but on planning and being in control of their finances.

The key focus is to generate a regular income and not to outlive their accumulated wealth. A Financially Fit older adult is happier and secure to manage Life Extension and proactively plan for Life Expansion landscape. This paper addresses five key areas of financial fitness for ageing adults with focus on proactive readiness to align with the key trigger events (1) Onset of Retirement (2) Relaxation, Activity and Recreation Planning (3) Personal Loss or Divorce (4) Onset of older age related conditions (5) End of Life planning.

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Assessment of Spiritual Needs of the Elderly Persons Climbing the Seven Hills of Tirumala on Foot for Darshan of Balaji

Lavanyakumari GC[1], Chandra Sekharan PA[2] ,Sridhar MS[3]

INTRODUCTION: Spirituality remains important social and psychological factor in the lives of older adults, and there is continued interest in examining the effects of spirituality on health status. The purpose of this study is to examine the assessment of spiritual needs of elderly. Assessing the spiritual needs in geriatrics can help us to strengthen the health care delivery tailored to their needs.

OBJECTIVES: 1. To know the elderly persons associate themselves with the God in their day to day life.

2. The expectations of elderly from the God.

STUDY METHODS: Study design:

A cross sectional study

Setting: A community based study in Tirupati in people age more than 60 yrs.

Sample size: A convenient or purposive sample of fifty elderly persons is chosen.

Duration : 2hours spell for 3 days

Instrument for assessment:

A schedule regarding spiritual needs is prepared for the purpose of the study.

METHODOLOGY:

1. A verbal consent was taken before the person is enrolled.

2. An interactive sesssion is held for 10-15 minutes and schedule is filled immediately thereafter.

3. Their responses are analyzed to get an insight into their spiritual needs.

Results: Need for gratitude (14), need for vision (3), need for personal dignity (2), need to be certain that there is a God or Ultimate power in the universe(3), need to believe that God is loving and personally present (9), and the need to contribute to or improve one's community(19) were mentioned

as important spiritual quest by the respondents.

CONCLUSION: Spirituality may be an important explanatory factor of subjective health status in older adults. So, in delivering health care services, a medical practioner should give value to the spiritual needs of the elderly and their family.

Perception of Tenth Class Students on Elderly

Madhusudana Pulaganti[1], A.S.Kireeti[2] , M S Madhuri[3], M.S.Sridhar[4]

Introduction: As an offshoot of the project on physiological, psychological and clinical assessment of geriatrics in Chittoor District, the perceptions of high school children on old age is explored and presented.

Objective: To record the perceptions of Secondary Grade Students on Care of Elderly and to interpret the data.

Design: Exploratory study involving discussion with Secondary School students on care of the elderly, their problems and possible solutions.

Participants: Xth class students of Government Girls' High School and Jawaharlal Nehru Municipal High School, Tirupati, Andhra Pradesh,India.

Method: This is an action cum research activity to create awareness among students through structured questionnaire and face to face interactions with 120 students of Xth class.

Results: Some of the perceptions of the students noted are 1. to keep the elderly happy, 2. To ensure their health, 3. To ensure financial security and problems associated with money, 4. Feeling of lacunae when they do not have grandparents, 5. Learning about past, present and future from grandparents 6. Sharing of their experiences, 7. Their counsel borne out of wisdom when the family is in trouble, 8. The zest and spirit with which they support their family, 9. Practice of indigenous medicine like Ayurveda, 10. Introduction to spirituality.

These positive perceptions are more in girl students compared to boys.

Conclusion: Elderly persons in the family are considered an asset and are perceived as a medium to imbibe culture, patience, learn about the importance of combined families, Indian civilization. They are a source of happiness and they make happy families. Where elders are not available, there is dependency in resolving family problems. These findings are useful to take measures to foster positive attitude towards elders and help in I E C activities. Introducing geriatrics education at secondary school level with appropriate content could be a promotive measure in furthering health and happiness of ageing population. Further it alerts the society to take care and likely bridge gaps in families regarding the care elderly receive.

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ECG and ECHO changes in acute stroke and its prognostic significance

Parimala Pydi [1], Balasubramanyam B[2], K Siva Prasad[3], M S Sridhar[4]

Objectives: To study different changes in ECG and Echocardiography patterns in acute cerebrovascular stroke and to assess their prognostic significance .

Methods: Changes ECG and 2D ECHO in fifty patients of acute cerebrovascular stroke within 24 hrs of admission were evaluated and in-hospital follow-up was done to know the prognosis of the patients.

Results: ECG abnormalities noted among cerebral infarct group are presence of U wave (51.47%) and prolonged QTc (36.76%), followed by T-wave inversion (30.88%), and ST segment depression (30.88%). In case of hemorrhagic stroke ST depression (56.26%) and U waves (56.26%) are most common. LV dysfunction was the most common 2D-ECHO abnormality in both types of stroke - 23.53% and 56.26% in infarct and hemorrhagic groups respectively.

Mortality was high in patients with 2D-ECHO changes (90.91%) $p<0.001$. 79 % of patients survived with abnormal ECG ($p>0.5$).

Conclusion: LV dysfunction is the most common 2D-ECHO abnormality that has prognostic significance in predicting mortality. ECG abnormalities in stoke patients did not have any prognostic significance.

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Reflection of an Emergency Resident towards the Geriatric Patient

Ramyakumar M

It is 8 pm time during my shift, I left for the emergency room. As soon as I reached E R, I saw all the medical and trauma bay filled with elderly patients. I was shocked and

then I realised that this is where we have come and we are paying the price for improved health care , which is of no use to the elderly; as a Resident I may read feel I know the whole physiology but 'No'. A breathless patient could be having decreased vital capacity or a fracture femur going in for embolism; an unconscious patient could be due to head injury due to fall which is common, elder abuse because of neglect and their disability or a multitude of medicines which they could be taking because of multiple co- morbid conditions, or a ventilated patient who wanted to take his life unable to undergo dialysis or hanged himself. I also came across an old man speaking to wife but she was unable to recognize her husband because of dementia. Tears almost rolled in my eyes when the son leaves his parents in the hospital or goes away due to lack of finances; some old lady expectantly waiting for his return. With a heavy heart, we take consent from a patient's relative for a Do not resuscitate directive (DNR). All these events, if they are so emotionally draining to us, how could it be for that old patient/s. He / she is someone's parent, grandma or grandpa. All they need is emotional assurance, a sense of psychological well being. A smile that we are there for you; we can come together and see a smile on their faces. With these thoughts, I complete my shift waving a bye to the Old man in the room.

Profile of Unknown Geriatric Patients Admitted in a Tertiary Care Hospital

Saraswatii B[1], Thulasiram K[2], Ramesh R[3], Sridhar M S[4]

Abstract category: Geriatric care.

Preferred mode of presentation: Platform.

Method: Retrospective study (Discriptive).

Abstract and results: A retrospective study done at SVRR Government General Hospital, attached to S V Medical College, Tirupati from 15th October, 2015 to 15th October, 2016. The aim of the study is to know the proportion of geriatric patients admitted in different wards and the proportion of ***'unknown'*** geriatric patients among all geriatric admissions, to study the disease profile among these 'unknown' geriatric patients and their hospital outcome. If the outcome of the disease is death, then cause of death is studied. In this study, it is observed that total admissions of geriatric patients are 7.4% of total hospital admissions. Male to female ratio is 1.8:1 and the proportion of 'unknown' geriatric patients is 2.33%; male to female ratio is 4:1. The common condition among these patients is metabolic disorders followed by sepsis and road traffic accidents. The outcome is observed to be poor, death being the highest outcome and the cause of death is aspiration followed by sepsis and hypotension.

Conclusion: Though the disease is treatable in the ***'unknown'*** patients, the lack of attendents to look after the patients, nutritional imbalance, non-ambulatory status, lack of social and emotional support to these patients probably led to the death of these patients.

Hence, there is need for comprehensive care which important for the overall improvement of health condition in 'unknown' geriatric patients.

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A Cross sectional Study of Social and Medical Problems of Elderly Persons living in an Old age home at Tirupati in Andhra Pradesh

Tejaswini G[1] , Chandrasekharan P A[2], Sridhar M S[3]

INTRODUCTION: Ageing, a natural phenomenon, is associated with many medical problems. Social change of joint family to small family is driving the elderly from their own homes to old age homes. As these issues of social and medical problems of old age should be addressed, the present study is undertaken in a typical old age home so that findings can give some insight into the dynamics of care of the elderly and living arrangements.

OBJECTIVE: To study the social and medical problems of elderly people living in old age home at Tirupati in Andhra Pradesh.

METHODS: Study design: Cross-sectional study using a schedule

Sample size: 30 elderly people

Sampling technique: Convenient or purposive sampling

Study setting: Old age home of Rashtriya Seva Samithi (RASS), a Central Government aided Non-Governmental Organization (NGO) with headquarters at Tirupati.

RESULTS: Majority of the inmates are in the age group of 65 to 70 years. Among 30 elderly-people, 92 % were married, 5 %widowed, 3 % unmarried. 85% are feeling isolated, 10 % reported depression, 5 % lack of social relationships, 5 % lack of recreational activities. Medically, 60 % had hypertension, 45 % diabetes, 10% high cholesterol, 60 % vision problems and 80 % arthritis.

CONCLUSION: The ageing of population poses both social and medical problems. Abandonment by children is found to be the main cause for feeling isolated. Among medical problems most of them are having arthritis, hypertension, and vision problems. So, more action based research should

be given priority to improve the quality of life. Most importantly, caring values should be inculcated in younger generation towards elderly. Medical professionals have an onerous task of creating awareness, at every opportunity, by using appropriate I E C activities.

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Care of geriatric patients with hemiplegia

V.Ujjwala[1] and M.S.Sridhar[2]

INTRODUCTION: Geriatric persons are people with age 60years or more. As patients presenting with brain stroke are increasing, it is the responsibility of the treating physician to explain the consequences, functional disability and the rehabilitation measures to be taken care of particularly in geriatric patients because these are the patients who are mostly abandoned by the family members or suboptimal care is provided.

OBJECTIVES: 1) To implement scoring systems to geriatric patients presenting with hemiplegia to know the functional disability.

2) To implement early rehabilitation measures for independent leaving of the elderly.

METHODOLOGY

STUDY: Based on Review of literature

RESULTS: As per the literature elderly persons whose functional and outcome assessment scales have been done after certain period of stroke onset can be able to assess patient prognosis and outcome .This will form the basis to provide care in the geriatric patients . The patients with early rehabilitation care had good activities of daily living compared to other patients .

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Role of support staff in the care of the elderly

Kiran V[1], Sridhar M S[2]

The care of the elderly needs multidisciplinary approach. The paramedical staff have an important role in the investigation of the medical problem and communicating properly for the optimum care. This has to be done in consultation with the medical professional caring for the elderly patient. The Public Relation Officer has a role in coordinating the care by interceding on behalf of the elderly patient. The experience gained at SVRR Government General Hospital, Tirupati is documented.

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CHILD to 'OLDIES' programme – An experience from Tirupati

Sridhar M S[1], Kireeti A S[2], Mrudula Y[3], Madhuri M S[4]

Following the example of ***Child to child*** programme conceptualized by Drs Hawes and Morley in 1978 which has brought palpable improvement in children's health in developing countries through enhancing children's role and place in their community, it appears to be a viable solution to involve children in providing for the needs of older persons, especially in terms of love and affection, companionship and care. The experience of a pilot project, 'Child to Oldies', from Tirupati is reported.

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Integrated Falls Prevention: An enabler to Active Ageing

Ms. Mateen Ansari,[1] Mr. Manish Rai[2]

Falls in older adults are potentially life threatening events and may be simply the first signs of a single problem, or a cluster of problems. Each year, one in three adults age 65 and older experience falls, mostly in their homes.

Falls often lead to loss of mobility leading to severe dependency, loss of confidence, long-term physical disability, social isolation and reduction in quality of life. Falls are caused by a combination of age and disease-related conditions and complex inter-related social, physical, behavioural and environmental risk factors.

The consequences of Falls go beyond the individual and affect the lives of family members and friends. Collectively falls in older adults are a major burden to the individual, their family, and the State health care system. Falls in the elderly are thus a problem with multi-dimensional complexity. An integrated approach with multidisciplinary and multiagency

commitment is required. It requires collaboration across community, healthcare providers, and professionals (both primary & secondary), elder care facilities, care givers and other stakeholders.

This paper puts forth a multidisciplinary Integrated Falls Prevention platform with a focus on grass root level networking and actions to reduce falls and fractures throughout the nation. This unified platform is built on the foundation of spreading awareness, mentoring and assessments across the lifespan of seniors. It will emphasize and address various phases and touchpoints in the lives of elderly. It will strive to strengthen community ties, encourage active seniors to engage with seniors with special needs and spread the movement with Train the Trainer programs across the country. An integrated, technology and data driven community based approach enables a systematic shift from a reactive to proactive management of Falls leading to a vision of predictive approach to falls prevention thereby enhancing active ageing in older adults.

1.Gerontologis, Senior Wellness Consultant, Advisor ICHHA, GYDYANTRA
2 Transformational Catalyst, Advisory Services, Co-Founder: Dobara

A Study of Correlates of Depression In Elderly Population of Rural Haryana

Dr Neelam Kumar[1], Dr Manju Rani[2], Dr Hitesh Khurana[3], Dr Neeraj Pawar[1]

Background: Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy and poor concentration.

Elderly are more prone to psychological problems and depression is the commonest geriatric psychiatric disorder. Many factors- biological, genetic and psychological are likely to contribute to the development of depression.

Material & Methods: The study was conducted, among elderly (age >60 years) in Chiri block, Rohtak Haryana. A total of 500 elderly were selected using multistage cluster sampling. GDS-30 (Geriatric depression scale) was used to find out prevalence & a pretested & semi structured schedule was used to collect the data on correlates.

The data were entered in the MS EXEL spread sheet, & then subjected to statistical tests using SPSS 20 software.

Results: Prevalence of depression among elderly was found to be 14.4 % (19.3 % in females & 8.7 % in males). About 43 % of total unmarried subjects showed depression, about 38 % of the married & 18% of widow/er, separated showed depression. Significant association was found for low literacy level, occupation status, and economic dependency with prevalence of depression.

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Gender differences and similarities in depression and anxiety among the geriatric population living in an urban slum of Delhi

Arora M [1], Gupta DK [2], Kumar A [3], Kapoor SK[3]

Objective: To study gender specific differences and similarities in prevalence and factors associated with depression and anxiety in the elderly.

Methods: A cross sectional study was carried out on 450 elderly (237 males and 213 females) participants aged 60 years and above in an urban slum of Delhi .Geriatric Depression Scale-Hindi version (GDS-H) and Clinical Anxiety scale (CAS) were administered on the participants to assess depression and anxiety respectively.

Results: Females had higher prevalence of depression (18.3%) than males (11.5%). The factors significantly associated with depression among males were lower socioeconomic status and smoking status, while among females were living alone, living with daughter's family, living in a nuclear family and lower socioeconomic status. Prevalence of anxiety in females was 13.1% as compared to 8.5% in males. The factors significantly associated with anxiety among males were lower socioeconomic status and living in a nuclear family, while among females was living alone, living in a nuclear family and lower socioeconomic status.

Conclusions: The above results suggest gender differences and similarities in prevalence and factors associated with depression and anxiety in the elderly. There should be further research on gender specific risk factors and health policies should adopt 'gender mainstreaming approach' while addressing their needs and concerns.

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News from Kolhapur

DR. SANJAY BAJAJ

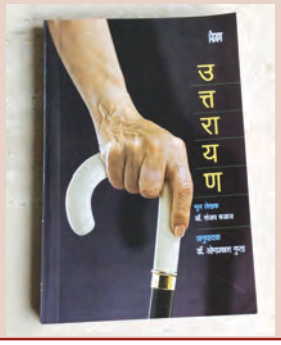
Kolhapur Chapter of Geriatric Society of India was inaugurated at Shahu Smarak Bhavan on 06th August 2016.

The central zone coordinator Dr. Sanjay Bajaj inaugurated the chapter & inducted the executive committee comprising of Dr. Anand Kamat as Chairman, Dr. Mahaveer Mithari as Secretary & Dr. Udyam Vora as Chairman Elect.

On this occasion President of Kolhapur medical association Dr. Pravin Hendre assured all the cooperation from members of medical fraternity in strengthening the hands of GSI Members to take care of the medical problems of the elderly.

President of the Kolhapur District senior citizen's organisation Dr. Mansingrao Jagtap & Principal Y. N. Kadam an employee of the R&D wing of Federation of Senior Citizen's Organisation in the state express the hope that the chapter will help in suitable as well as cheaper treatment for elderly patients.

Chairman of the GSI chapter Dr. Anand Kamat said, that the members appointed in the GSI chapter will educate the doctors on geriatric health care & expand the scope to home care, stress will be given on preventive strategies.



UTTARAYAN, the Hindi edition by Dr. Sanjay Bajaj was released by KMA president Dr. Pravin Hendre.

Inauguration was followed by CME for doctors.

Dr. Deepak Joshi renowned orthopaedic surgeon delivered lecture on" Orthopaedic problems in Geriatrics"

Dr. Anita Basavraj (Chairperson of GSI Pune) expressed her thoughts on "Elderly Medicine"

Dr. Sanjay Bajaj (Central zone coordinator GSI) addressed about falls in elderly.

Dr. Sanjay Ghotane treasurer of GSI gave vote of thanks.

The function was graced by doctors, senior citizens, different organisations & medical students.

An article on "Falls Prevention Awareness" by Dr. Sanjay Bajaj was published in Sakal 23rd August 2016.

News From Vidarbha Chapter

DR. SANJAY BAJAJ

Dr. Jayant Pande, Bhorayar, Capt. Dr. Anil Deoghare, Dr. Sanjay Bajaj, Dr. Deabshish Chatterjee, Dr. Madhukar Kherde, Dr. Sudhir, Dr. Diwakr Mangrulkar.

Geriatric Camp in at Darekasa in Naxlite Area by Geriatric Society of India, Vidarbha Chapter

News From West Bengal

DR. KAUSHIK RANJAN DAS

Geriatric Society of India West Bengal Branch and Barrackpore Elderly Care Society celebrated **World Elder's Abuse Awareness Day** (WEAAD) on 15.06.2016 by organising a street corner meeting at Mohanpur. The president of Ever youth club with its members also joined the meet.

Different aspects related to social, economical, psychological and medical problems of elderly were discussed along with matters of Elder Abuse. After a threadbare discussion, the following resolutions were adopted.

1) Since constitution of India has vested duties on the state Govt. to help elderly in distress, it is urged that state Govt. will direct its administration (both civil & police) to take appropriate measure regarding security, peace & other matters of elderly as & when reported by a person or on his behalf. The order related to this end should be circulated widely.

(2) Appropriate amendment in police regulation needs to be made, inserting provision of grave punishment for noncompliance/ negligence in this regard.

(3) As a measure for strengthening family bonding, appropriate changes to be made in the Govt. servants conduct rules & provisions for caring parents of dependent must be made.

(4) State policy in the form of rules under Maintenance

of Parents & Senior Citizens Act. 2007 be passed immediately in the Legislative assembly including different aspects of prevention of elder's abuse. State should take step for amendment of MP&SC Act. & to include daughter in laws in the meaning of children and compulsory physical attendance of kids to their parents/relatives residence.

(5) State Govt. should take step, so that a penal provision be enacted immediately in the Parliament for protection of elderly from torture.

A system of reward may be started for good kids/ caregivers.

News from Kerala

BABU

Social Justice Department of Govt. of Kerala has come up with Old age home Guidelines Draft.

To see the guidelines please visit the below link

http://www.swd.kerala.gov.in/images/VIKASBHAVAN/yuuyuuideline.pdf

News from Vijayapura

DR. ANAND P AMBALI

Geriatric Clinic of BLDE University, Vijayapura headed by Dr. Anand P. Ambali has been awarded "Best Geriatric Services Unit 2016" by Govt. of Karnataka.

GSICON 2016

(10 - 11 December 2016)

Vallabhbhai Patel Chest Institute, Delhi - 110007

Saturday 10 December 2016

Time		Topic	Speaker	Chair Persons
08:31 AM - 09:00 AM			YOGA	
09:01 AM - 09:20 AM	Rekitts Geriatric Oration	Hyponatremia	Dr. N. S. Neki	"Dr. Anita Basavraj Dr. Rajkumar"
09:21 AM - 09:40 AM	Presidential Oration	Chronic Cough in Elderly	Dr. S. N. Gaur	"Dr. D. K. Hazra Dr. O. P. Sharma"
09:41 AM - 10:00 AM	L. C. Manoria Memorial Oration	Palliative Care Needs of a Patient with Dementia	Dr. Prabha Adhikari	"Dr. B. Srihari Rao Dr. R. M. Sundrani"
10:01 AM - 10:20 AM	Guest Lecture	Pre-operative Assessment	Dr. Pratibha Pereira	"Dr. Anand Ambali Dr. Prabha Adhikari"
10:21 AM - 10:40 AM	Guest Lecture	Frailty	Dr. P. S. Shankar	"Dr. V. K. Arora Dr. A. K. Singh"
10:41 AM - 11:40 AM	Novel Thoughts	Vicissitudes of Normal Ageing Ageing & Medication Ageism in India : Myth or Reality	Dr. Vinod Kumar Dr. B. K. Mondal Dr. Aditya M. Yeolekar	"Dr. A. S. Kireeti Dr. Kauser Usman"
11:41 AM - 12:10 PM	Guest Lecture	Coronary Interventions	Dr. Ashok Seth	"Dr. S. K. Dhingra Dr. A. K. Prasad"
12:11 PM - 01:10 PM			INAUGURATION	
01:11 PM - 02:00 PM			LUNCH	
02:00 PM - 03:00 PM	Symposium on Infections	Immunity Issues Choice of Antibiotics Tuberculosis - Standard of Care	Dr. Sajesh Asokan Dr. Sandeep Tamane Dr. Rohit Sarin	"Dr. Mandira Varma Basil Dr. B. Janardhana Raju"
03:01 PM - 03:20 PM	Guest Lecture	Imaging in Elderly	Dr. Harsh Mahajan	"Dr. B. K. Menon Dr. B. B. Gupta"
03:21 PM - 03:40 PM	Guest Lecture	Anti Oxidants - Any Role	Dr. Padma Mallika Khanna Hazra	"Dr. Nikhil Sarangdhar Dr. Sagar Borker"
03:41 PM - 04:00 PM	Mithilesh Memorial Lecture	Falls : Revisited	Dr. A. K. Singh	"Dr. Anil Manchanda Dr. V. G. Warad"
04:00 PM - 05:30 PM			Free Papers	
05:30 PM - Onwards			Annual General Body Meeting	
07:00 PM Onwards			BANQUET	

Sunday 11 December 2016

Time		Topic	Speaker	Chair Persons
08:31 AM - 09:00 AM			LAUGHTER SESSION	
09:01 AM - 09:20 AM	"Dr. B. N. Srivastav & Saran Dulari Oration"	COPD in Elderly	Dr. R. M. Sundrani	"Dr. P. S. Shankar Dr. Badabade Parisha Jakana"
09:21 AM - 09:40 AM	Dr. J. J. Rao Oration	Organization of Geriatrics Education, Geriatrics Care and Research	Dr. M. S. Sridhar	"Dr. Sachin Desai Dr. Vivek Handa"
09:41 AM - 10:00 AM	Dr. G. S. Sainani Oration	A Clinical Profile of Diabetes in Elderly	Dr. J. K. Sharma	"Dr. Atul Kulshreshtha Dr. B. M. Makkar"
10:01 AM - 10:20 AM	"Dr. Raghunandan Lal Prabhakar Oration"	Management of Diabetes in Indian Elderly	Dr. M. V. Jali	
10:21 AM - 10:40 AM	Guest Lecture	Cognitive Decline	Dr. D. K. Hazra	"Dr. Ish Kathpalia Dr. Kaushik Ranjan Das"
10:41 AM - 11:40 AM	Symposium	"Influenza - International Scenario Influenza - Indian Scenario Influenza - Challenges to be meet"	"Dr. Abraham M. Palache Dr. Randeep Guleria Dr. A. K. Prasad"	"Dr. I. S. Jain Dr. Madhu Khanna"
11:41 AM - 12:10 PM	Guest Lecture	Intervention in Rhythm Disturbances	Dr. Viveka Kumar	"Dr. K. Ravi Dr. B. K. Mondal"
12:11 PM - 12:30 PM	Guest Lecture	Geriatric Emergencies	Dr. Anita Basavraj	"Dr. S. C. Sharma Dr. Sanjay Kambar"
12:31 PM - 12:50 PM	Dr. B. C. Bansal & Dr. C. Prakash Oration	Clinical Assessment in Elderly	Dr. Anand Ambali	"Dr. M. S. Gudi Dr. Sajesh Asokan"
12:51 PM - 01:40 PM	LUNCH			
01:41 PM - 02:00 PM	Guest Lecture	Ageing Face	Dr. Racchana Fadia	"Dr. D. K. Hazra Dr. Garima Handa"
02:01 PM - 02:20 PM	Dr. Satish Gulati Bharatji Gulati Oration	Elderly Care: Neuropsychological Perspective	Dr. Ashima Nehra	"Dr. Satish Gulati Dr. Ajay Jain"
02:21 PM - 03:00 PM	Symposium on Falls	Falls in Rural Elderly & Ageing	Dr. Mateen Ansari	"Dr. Vivek Handa Dr. N.C. Khurana"
		Neurological Causes	Dr. Ashima Nehra	
03:01 PM - 04:00 PM			CONVOCATION	
04:01 PM - 04:15 PM			VALEDICTORY SESSION	

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