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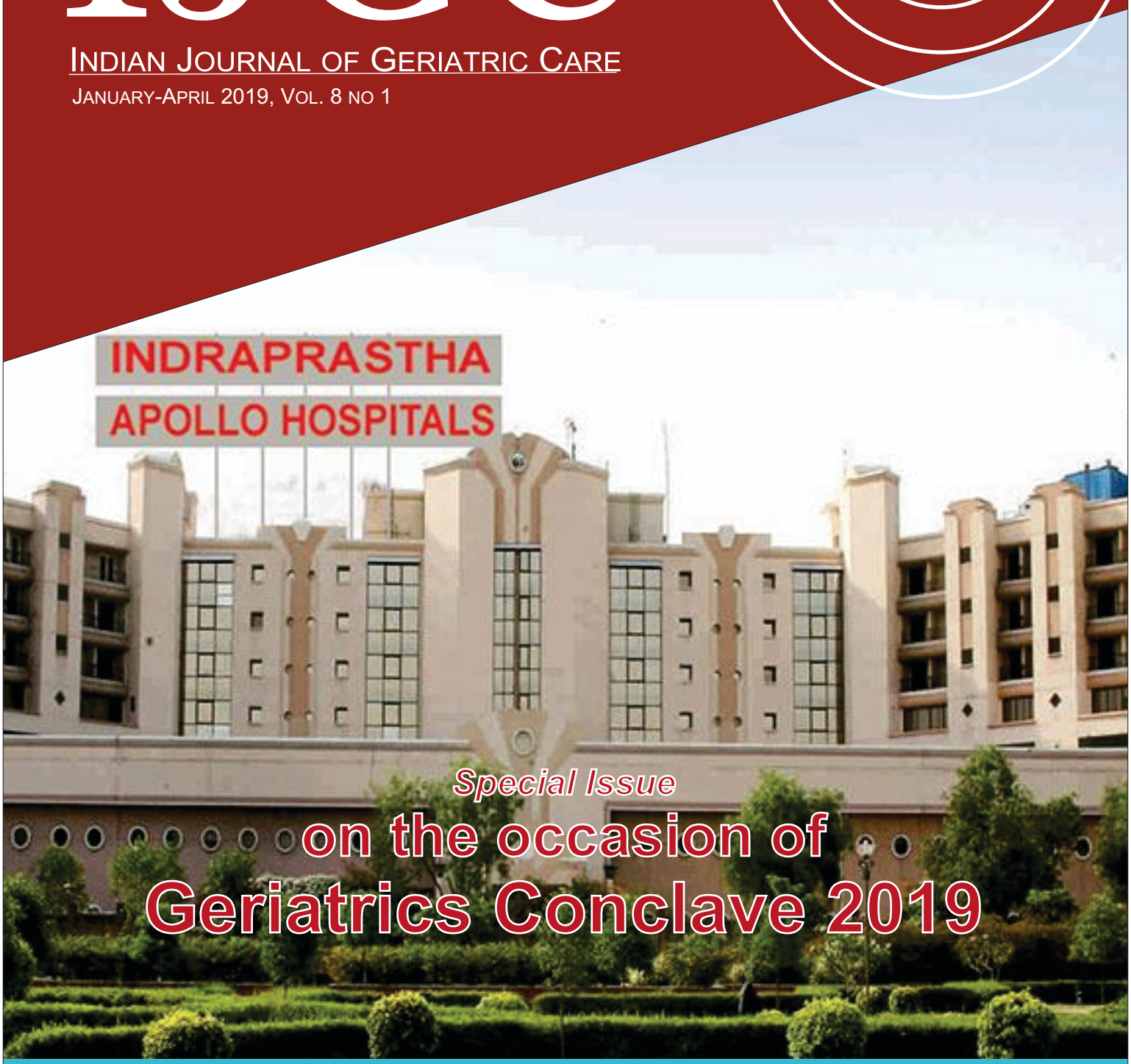

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on the occasion of Geriatrics Conclave 2019

Theme: Geriatrics in India - Opportunities & Challenges

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Enquires concerning subscription, advertisement, etc, should by addressed to Dr.O.P.Sharma, Editor-in- Chief , IJGC, K-49 Green Park Main New Delhi 110016.
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CONTENT

OP Sharma
National Professor of Geriatric Medicine,
HOD, Department of Geriatric Medicine, Apollo Hospital, Delhi
& Secretary, Geriatric Society of India.

Geriatric Care: Solution for India

Ageing is progressive, generalized impairment of function resulting in loss of adaptive response to stress and in increasing risk of age-related diseases.[1]

The majority of developed countries became developed first & then face the problem of ageing while the situation is reverse in India where we have a huge elderly population and we are still a developing nation. The social transition in the form of breaking up of age-old joint family system, due to migrations and economic compulsions has led to medical and health problems for elderly, besides socioeconomic issues. A vast majority of elderly still live in rural areas also. In India the life expectancy was 34 years in 1947, which has jumped to 68.2 years by the year 2018, currently the number is 112 millions.

INFRASTRUCTURE[1]

As on today medical infrastructure in the government sector comprises of 29 thousand primary health centres, 900 district health centres, we have 4256 rural hospitals, 3300 urban hospitals including those attached to 460 medical colleges. Under AYUSH (Ayurveda, Yoga, Naturopathy, Unani, Siddha and Homeopathy) we have 2394 Ayurvedic hospitals, 13887 dispensaries, 261 Unani hospitals and 1010 dispensaries, 280 Siddha hospitals and 463 dispensaries, 7 Yoga hospitals and 71 dispensaries, 21 Naturopathy hospitals and 56 dispensaries, 228 Homeopathy hospitals and 5803 dispensaries in the country under central government, state governments and other bodies likes Railways, ESI. We have now equally strong corporate & private setup in the form of hospitals as well as clinics of nearly two lakhs doctors throughout length & breadth of country.

All these facilities grossly fall short to cater the medical & health needs of mammoth Population of 1.33 Billion people. Out of this the number of elderlies is around 112 million. In the country we have five medical colleges with specialization in Geriatric medicine (Amrita University, Kochi, AIIMS, Delhi, CMC Vellore, Madras Medical College, Chennai, MGM, Mumbai, Kavery Medical Centre and Hospital (KMCH), Chennai) & about 25 hospitals with Geriatrics wards / clinics. Diploma in geriatric care only at St. Joseph's College (SJC), Bangalore & Sanjeevni Institute of Paramedical Sciences (SIPS), Chandigarh. Indira Gandhi National Open University also offer PGDGM (Post Graduate Diploma in Geriatric Medicine) degree of one year with contact programs in all state capitals.

The modern medicine system is however unfriendly, as one has to go to hospital / health care centre repeatedly for consultation, getting investigations done, collecting the reports, meeting the doctor again & then getting prescription for the same & finally getting medications. There is an urgent need to streamline this process of medical check-up to dispensing be under one roof & facilitated/assisted.

National Programme for the Health Care of the Elderly (NPHCE) was conceptualized in 11th five-year plan. During the 12th Five-Year Plan, the remaining districts are to be covered in a phased manner at the rate of hundred districts per year.

PLANNING FOR THE ELDERLY

From health care point of view this group can be divided in 3 subgroups. *Young old (60* to 74yrs) which are Independent and gainfully employed. Their Medical & Health needs are like young people & they may be looked after by physicians/ Geriatricians; *Old old* (75 to 84 years) need more of assistance & nursing care rather than medical help; *Very Old* (>85yrs) and above are mostly dependent requiring domiciliary Care or Hospital Care.

All the above three categories may be managed by a good general practitioner with an extra briefing on Ageing, the clinical differences between adults and elderly, Geriatric Syndromes, geriopharmacy & Drug Interaction, Physiotherapy, Diet, Preventive Aspects and Social issues like elder abuse needs to be carried out. Briefing can be by short courses, telemedicine, bulletins & Mass Mailing Service in Regional Languages. Help centres have been established in five areas of the country and managed by Central Government/State Government/NGOs/Pharma Industry.

FOR THE POPULATION WHO IS APPROACHING 60 YEARS

Regarding second category i.e. the people who are approaching old age; one can attempt to herald the process of ageing & prevent the diseases by lifestyle changes & preventive measures to combat infections & nutritional diseases.

For those who are getting aged, the planning may be done by adding geriatrics in the medical curriculum. We may sensitise budding doctors about special aspects of geriatrics in their teaching & training. For this we may add ageing, immunity, geriopharmacy, geriatric syndromes, dementia, frailty, andropause, menopause, osteoporosis, nutrition & physiotherapy in their under graduate curriculum.

GENERAL MEASURES

Ageing will continue & number of elderlies will rise. Number of comorbidities (Diabetes, COPD, Hypertension & Heart Failure) will rise, because of changes in lifestyle. Accidents & falls will also increase. Due to change in social setups & migrations, the family support will dip & the cost of living as well as treatment will continue to rise.

We have to have improvements in nutrition, housing & things of daily needs.

People should be educated about the Misuse of over the counter drugs like analgesics, painkillers & antibiotics. The polypharmacy should be minimized/avoided in elderly as it causes increased incidents of drug interactions.

The use of vaccines like Hepatitis B, Typhoid, Meningococcal, Influenza, Pneumococcal, T-dap & Zoster which are advised in elderly should be encouraged.[2]

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Drugs in Elderly Patients with Kidney Disease

*DEODATTA CHAFEKAR

Abstract

With advancing age, the functional reserve of many organs tends to decrease. The renal function may also be impaired in elderly by the concomitant presence of acute or chronic kidney disease and is often affected by co-morbid conditions. There are various structural and functional changes which occur in the kidney with ageing. In elderly we have to determine the loading dose and the maintenance dose. In most situations ,there is no change in the loading dose. The maintenance dose can be adjusted by reducing the dose or increasing the dosing interval or both.

Keywords: *CKD (Chronic kidney disease), AKTI (Acute kidney injury), eGFR, Albuminuria, TBW (Total body water).*

INTRODUCTION[1]

The life expectancy is globally estimated at 67.2 years, averaging 76.5 years in developed countries and 65.4 years in developing countries.[2] As a result, approximately monthly 870,000 people cross 65 years, and this figure is projected to grow to almost 2 million a month over the next 10 years.[2] Globally, the number of elderly is expected almost to triple, from 743 million in 2009 to 2 billion in 2050.[2]This rise in the elderly population has prompted to have a separate subspecialty of Geriatrics, which caters to their health issues as they need a different approach than similar health problems in young population.

With advancing age, the functional reserve of many organs tends to decrease. Kidneys are one of such major organs which get affected due to ageing. The kidneys undergo important age-related changes in function and structure & show decrease in their filtration capacity as the age advances. The renal function may also be impaired in elderly by the concomitant presence of acute or chronic kidney disease and is often affected by co-morbid conditions like diabetes & hypertension. 50% of Nephrology patients are older adults. NHANES data suggests 40% of adults >60 yrs have CKD.[3] AKI insult also is more common due to structural changes.30% of hospital admissions >60 yrs age develop AKI. Recovery times in them are longer due to co-morbidities.

While considering use of medications in the elderly, it is vitally important to understand various aspects of :

a. Structurally and functionally ageing kidney
b. Special features attributable to kidney disease (Acute or Chronic) in the elderly.

There are various health issues in the elderly which cause frailty and various geriatric syndromes. ageing causes changes in body compositions, discrepancy in energy production and utilization, homeostatic dysregulation and neuro-degeneration. This results in many consequences like cognitive impairment, malnutrition and disability. We all know that the estimated population of elderly individuals (>65 years of age) is expected to triple in the next 10 years. 50% of nephrology patients are older adults. 30% of hospital admissions >60 years of age develop AKI (Acute Kidney Injury). Hence the incidence of the chronic kidney disease and patients requiring renal replacement therapy, due to ESRD (End stage renal disease) is also rising. In order to respond to this growing challenge, geriatric nephrology is emerging as a new field of special interest for the nephrologist. While caring for the elderly patients with kidney disease, a geriatric physician – nephrologist collaboration is required,[5] which should result in co-management of geriatric renal disease. For example, geriatric specialist is responsible for

*Director & Consultant Nephrologist, Supreme Kidney Care, Nashik

comprehensive geriatric assessment of functional, cognitive and psycho-social factors, early identification of renal disease, treatment of co-morbidities and planning of long term care. The nephrologist would be responsible for conservative treatment of CKD and planning and execution of renal replacement therapy by way of dialysis or kidney transplantation. There are various issues related to medical ethics and palliative care, which require careful dialogue with the patient and the family.

THE AGEING KIDNEY

There are various structural and functional changes which occur in the kidney with ageing. Histological changes include, glomerular sclerosis, tubular atrophy and interstitial fibrosis & hyalinosis of afferent and efferent arterioles. Gross changes with age include 30% loss in size of the kidney by the 8th decade and decrease in renal mass by 300 gms by the 9th decade. Functional changes in the ageing kidney include decrease in the renal blood flow by 10% per year, resulting in GFR decrease by 0.87ml/min/year and reduction in the concentrating and diluting capacity of the kidney.

MEASUREMENT OF KIDNEY FUNCTION

Kidney function can be measured by following methods:

1. Serum Creatinine
2. 24 hours Urine-Creatinine clearance
3. Cystatin C
4. Prediction equations
5. Direct GFR measurements (Inulin clearance and Radionuclide studies).

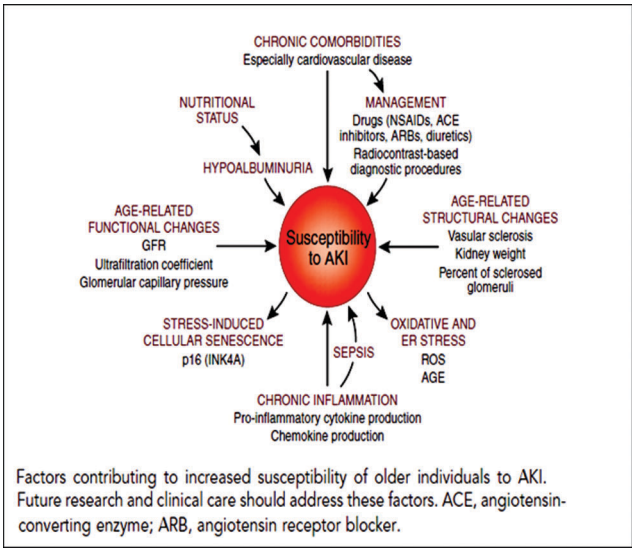
The best methods are Inulin clearance and Radionuclide studies. However these are tedious and frequently unavailable.

Serum creatinine is the most easily available test as a measure of renal function. However, ageing, racial variation, muscle mass, diet and medications affect its measurements. Hence it is the most inaccurate method.

eGFR (estimated GFR) is now considered a standard method as a measure of renal function. eGFR can be calculated by the MDRD equation or the CKD-EPI formula. Cystatin C based eGFR (instead of serum creatinine) can also be used with more accuracy. In the elderly population, the eGFR, unfortunately has not been standardized, but still is the most standard and accepted method.

AKI IN ELDERLY

AKI is more common in the elderly due to the structural and functional changes which occur with ageing as well as frequently associated co-morbidities.



Factors contributing to increased susceptibility of older individuals to AKI. Future research and clinical care should address these factors. ACE, angiotensin-converting enzyme; ARB, angiotensin receptor blocker.

Prevalence of AKI in this population is about 30%. Recovery of renal function is much slower. AKI is also associated with prolonged hospitalization, in hospital mortality and progression to chronic kidney disease.

Diagnosis of AKI is more difficult in these situations and hence we need biomarkers like NGAL for early diagnosis of AKI before rise of serum creatinine.

Adapted from[7] : Acute Kidney Injury in Older Adults, Sharon Anderson et al, JASN January 2011, 22 (1) 28-38; DOI: https://doi.org/10.1681/ASN.2010090934

General approaches for prevention of AKI include:

1. Avoidance of nephrotoxins
2. Timely correction of dosage schedule
3. Maintaining Euvolemia
4. Early diagnosis & treatment of nosocomial infections
5. Maintenance of haemodynamic stability.

Prognosis of CKD by GFR and Albuminuria Categories: KDIGO 2012

GFR categories (ml/min/ 1.73 m^2) Description and range				Persistent albuminuria categories Description and range		
				A1	A2	A3
				Normal to mildly increased	Moderately increased	Severely increased
				<30 mg/g <3 mg/mmol	30-300 mg/g 3-30 mg/mmol	>300 mg/g >30 mg/mmol
	G1	Normal or high	≥90			
	G2	Mildly decreased	60-89			
	G3a	Mildly to moderately decreased	45-59			
	G3b	Moderately to severely decreased	30-44			
	G4	Severely decreased	15-29			
	G5	Kidney failure	<15			

Green: low risk (if no other markers of kidney disease, no CKD); Yellow: moderately increased risk; Orange: high risk; Red, very high risk.

Chronic Kidney disease (CKD) in elderly

The new definition of CKD, as defined by KDIGO includes, GFR and albuminuria for characterization and staging of CKD.

Common risk factors for CKD in elderly include, hypertension, diabetes mellitus, cardiovascular diseases and medications.

Drug dosing in the elderly[6]

Following is the stepwise approach for drug dosing in elderly patients with CKD .

1. Obtain pertinent medical history including co-morbidities
2. Assess renal function by eGFR
3. Review current medications
4. Individualize medication regimen
5. Monitor for drug toxicity

Principles of drug dosing

The fraction of an administered drug that reaches the systemic circulation depends on its absorption, distribution, metabolism and elimination.

These variables are dependent on factors like oral absorption,body fat content, serum albumin levels and hepatic and renal function.

With ageing and CKD, absorption is affected due to reduced splancnic blood flow and decreased intestinal metabolism, distribution is affected by decreased TBW (Total Body Water) and increased body fat. Metabolism is affected by reduced hepatic blood flow. Elimination is affected by AKI or CKD. There are some changes in pharmaco-dynamics like change in the affinity of drug to receptor, reduction in number of receptors and changes in cellular responses after receptor activation. Hence adverse drug reactions occur more commonly in the elderly.

DOSAGE ADJUSTMENTS IN ELDERLY[4]

After medical history, physical examination and assessment of renal function, we have to determine the loading dose and the maintenance dose. In most situations ,there is no change in the loading dose. The maintenance dose can be adjusted by reducing the dose or increasing the dosing interval or both.

The method of Welling and Craig, provides the estimate of the ratio of the uremic elimination rate constant (ku) to the normal elimination rate constant (kN) on the basis of creatinine clearance.

From the ku/kN ratio, the uremic dose can be estimated according to the following equation

Uremic dose = ku/kN X Normal dose .

Similarly dosage interval (Tu) in uremia can be calculated by following equation .. Tu = kN/ku X TN(dosage interval in normal patients).

There are nomograms available for elimination rate constants (k_N)

Some patients will require therapeutic drug monitoring (TDM).

Other issues in the elderly include:

1. Overdosing due to wrong calculation of eGFR.
2. Under dosing due to fear of side effects
3. Non adherence due to polypharmacy
4. Malnutrition
5. Drug interactions
6. Poor cognitive function

Recommendations for the drug prescription in the elderly

1. START LOW, GO SLOW
2. USE LIMITED NUMBER OF DRUGS
3. SIMPLIFY TREATMENT
4. CHECK PRESCRIPTION FOR DRUG INTERACTIONS
5. MONITOR RENAL FUNCTION PERIODICALLY
6. CHECK PSYCHO-SOCIAL AND COGNITIVE ABILITY.

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Untrodden Pathways in Senior Care

*SATISH TEMBE

Abstract

With rise in Senior population from 104 million in 2011 to a projected figure of 300 million by 2050 & Thanks to Shoe String National Health Budget senior care is bound to deteriorate. In geriatric practice, Polypharmacy has become the rule. One complaint, one medicine is not a sound approach. Seniors are not interested in a particular pathy. They are interested in Cure-o-Pathy or Care-o-Pathy which is economical, maintains their Quality of Life (QOL) & Dignity with a touch of Sympathy & Empathy.

Keywords: *Senior care, Medical health insurance, Polypharmacy, Complimentary medicine, Quality of life (QoL)*

"Doc ! Give me Euthanasia. I don't want to be a Burden on my family."— A Retd. Prof of Physics, Age 74

"Doctorsab Buddhe Walid Ki Khatiya kab Khaali hongi? Teen Mahine baad Beteki Shaadi honewali hai" — Car Mechanic Age 57

"Satishdada give my ailing mother marayache (Fatal) Injection I am tired of her illness." Our Maid Servant Age 40

"Son expels his Mother & Industrialist Father from the house after transfer of Rs. 1000 Cr. shares + House in his name"

These are true incidences which show a "*Jhalak*" (glimpse) of Senior care in all socioeconomic Strata of Indian Society.

This trend picked up momentum after 1990 when Indian Economy was opened to the rest of the world. This precisely was the time when License to Heal changed Hands from Physicians to MNC Corporate World. I.M.F.'s Gini Coefficient which was 45 in 1990 slid to 51 in 2013 indicating Rising Income Inequality in India.

With rise in Senior population from 104 million in 2011 to a projected figure of 300 million by 2050 & Thanks to Shoe String National Health Budget senior care is bound to deteriorate.

With recent discovery of the Science of "Psycho Neuro Immuno Endocrinology" many somatic ailments originate in the mind.

Due to increased stress levels, Anxiety Depression, Insomnia sets in which acts through Neuro transmittters, cytokines & hormones to cause Inflammation, Pain, Arthritis, Allergies, Infections etc.

Outwordly manifestations of this Jigsaw puzzle are Financial i.e. old age poverty, Life style diseases, Reduced Physical & Mental abilities, Forgetfullness, Fear of Fall, Fractures, Frequency of Urine, Constipation, Dependence on others.

" *Retirement is working definition of hell* "as per George Bernard Shaw.

Sadly, medicine which used to be a Service Industry has now become Production Industry with Corporate Honchos calling the shots. Young medical Graduates working for Corporate Hospitals are trained less into medicine, more into marketing. Hippocratic Oath & Medical Ethics are occupying back-seat now.

With New Imaging Techniques, Minimally Invasive Surgery, Nano-technology Diagnosis has become more accurate, Treatments have become more precise with less physical discomfort, less morbidity & to some extent less mortality. However costs have skyrocketed which a handful 5 to 10% Indians can afford.

Majority of Senior citizens today have no medical Health Insurance. They opt for small private hospitals which are closing down due to New Governmental Norms (NABH) . So they have to opt for Govt. Hospitals which are poorly staffed, ill-equipped, teeming with poor patients.

In geriatric practice, Polypharmacy has become the rule.

*

A patient under care of a Cardiologist, Diabetologist & Rheumatologist could well be taking 12-15 medicine/day. With poor memory, cataract & confusion, treatment compliance can be affected causing more harm than good.

Many a times spending adequate time with the patient, listening to his complaints patiently relieves his anxiety & half the illness. One complaint, one medicine is not a sound approach.

There are many different healing systems in the world. Allopathy is just one of them. Ayurved, Homeopathy, Unani are major Non-Allopathic systems which are widely accepted. Apart from these Acu-puncture, Acu-pressure, Hypnotherapy, Naturopathy, Aroma Therapy etc are termed as complimentary medicine which also are effective in chronic conditions.

Some common aliments like Constipation can be due to untreated Large Hernias which vanish after Hernia Repair. Recurrent UTI can be due to Enlarged Prostate, Stricture Urethra which needs endoscopic Surgery.

Diabetes has become a common problem. Apart from Obesity, Lack of Exercise, Presence of Septic Teeth or Carbuncle on Neck, Paronychia, Perianal Abscess can aggravate it. Elimination of these *Sleeper Cells of Sepsis* is of cardinal importance in control of diabetes mellitus.

Fall is a major cause of Mortality and Morbidity in old age. Apart from medication, one needs to improve Seniors' fitness level, & his environment. Improving power in lower limbs & spine with weight training definitely helps.

Non Slip Floor & Footwear, improving Nocturnal visibility with adequate light in Bedroom makes a lot of difference. Slow rising from Bed at night is advised to prevent vertigo. Wearing clothes in sitting position is advised. Such Preventive measures prevent accidents.

Recurrent URTI, LRTI, UTI in elderly are due to Resistant pathogens where antibiotics do not help. Good High protein Nutritious Diet, Anabolic Steroids can improve Non specific Immunity. Neutraceuticals i.e. Herbs & Spices from Indian Kitchen like Ginger, Cinnamon, Turmeric, Fenugreek, Lemon grass can help in fighting Infections & Productive Cough.

Alzheimer's is a major Neuro degenerative disease of old people & main cause of Dementia. Its incidence is rising all over the world. Early onset below 65 years is seen in 5% to 10% of people. Its treatment causes a great financial & social burden on the society.

Prevention of Alzheimer's by improving Diet, adding Coconut oil to diet, having support groups, improving social network. *Less dependence on Technology, Less Automation in Daily activities, Neurobics* i.e. Aerobic Exercise for cerebral neurons by various methods can delay or prevent this dreadful disease.

Seniors are not interested in a particular pathy. They are interested in Cure-o-Pathy or Care-o-Pathy which is economical, maintains their Quality of Life (QOL) & Dignity with a touch of Sympathy & Empathy.

GERIATRICS CONCLAVE

Organized by

Indraprastha Apollo Hospitals & Geriatric Society of India

20-21 April 2019

Auditorium, Indraprastha Apollo Hospitals,
Sarita Vihar, New Delhi-110076

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MESSAGE

Dr. Prathap C Reddy
Chairman,
Apollo Group of Hospitals

The population of elderly is rising the world over and Indian numbers aren't far behind. Advancements in diagnostics and therapeutics have led the transition from average span of 50 years to 70 years and beyond.

At Apollo group, my dream of "health care for my fellow citizens" is making rapid strides. We have always been at the forefront of acute, chronic, tertiary, palliative, home and nursing care. This has been possible by continuously investing in intellectual scientific knowhow of international standards.

The concept of Geriatric services led by Geriatrician, Geriatric nurse, Physiotherapist, Nutritionist and other specialists on need base is well established in Apollo group of Hospitals and provides best possible benefits of good health to all our senior citizens not just from our country but from other nations as well.

I am happy that our Geriatricians through this "Geriatrics conclave" plan to further update the latest scientific information to all levels of care givers.

I wish them great success.

MESSAGE

Dr. Sangita Reddy
Jt. Managing Director
Apollo Group of Hospitals

AGES

Ageing does not affect only the elderly; it affects everyone in society in some way or the other. Globally, the elderly population constitutes 12% of the total population of 7.3 billion and in India too, the percentage of elders has been increasing in recent years.

According to recent studies, India is ageing much faster than previously thought and may have nearly 20 per cent population of 60 years and above by 2050. In a parliamentary session, the Government stated that India will have 34 crore people above 60 years of age by 2050, which is more than the current population of USA. This situation will pose twin challenges of rising population and old age dependents, adding to a greater need of providing jobs, education, and health along with geriatric care.

Population ageing is an inevitable demographic state associated with improvements in health and advances in medical care. Therefore it is paramount that everyone, including the government, the community, the medical fraternity and families participate in ensuring that the elderly are valued, respected and are active members of society.

Therefore, it is commendable that the Geriatrics Conclave 2019 is being conducted with a view to encourage and nurture scientific contributions and sharing of clinical knowledge. On behalf of the entire Apollo Hospitals family, I would like to extend our best wishes to the faculty and delegates for a fruitful programme.

With best wishes,

MESSAGE

Dr. Anupam Sibal
Group Medical Director
Apollo Group of Hospitals

The number of elderly in India is projected to reach 158.7 million in 2025. By 2050, the elderly population will surpass the population of children below 14 years. As we are witnessing the most important phase of demographic transition in India, the importance of 'Geriatric Medicine and Gerontology' can no longer be overlooked.

Improvements in healthcare have resulted in increased longevity. The average lifespan is now 65 years. Current statistics for the elderly in India gives a prelude to a new set of medical, social, and economic problems that could arise if a timely initiative in this direction is not taken by program managers and policy makers.

The medical and socio-economic problems that are being faced by the elderly people in India need to highlighted and strategies for bringing about an improvement in their quality of life needs to be explored. The elderly need to be supported for 'active ageing' so that they can live a respectable life being active members of the society.

At Apollo, we are forever innovating to improve the scope and scale of our services.

The concept of Geriatric services led by Geriatricians, Geriatric nurses, Physiotherapists and Nutritionists is now being established in the Apollo Group of Hospitals so that benefits of good healthcare to all the senior citizens can become a reality.

*The **Geriatric Conclave** being held on **20th and 21st 2019** is a step in the right direction for serving the elderly with empathy based on the latest scientific knowledge.*

This Geriatric Conclave is an example of exploring, embracing and implementing newer approaches.

I wish the event a grand success.

With warm regards

Yours sincerely

MESSAGE

Dr. Ashok Bajpai
MD, Indraprastha Apollo Hospital,
New Delhi

It is an honour and a privilege for Apollo Hospitals to be associated with the Geriatric Society of India for the care of India's elderly. Despite being a young country, India's geriatric population is expected to triple by 2050, that is, from 100 million at present to 300 million by 2050.

Focus on geriatric care is only just emerging in India. According to a 2011 report by the Ministry of Social Justice, nearly 160 out of every 1000 elderly suffer from Heart diseases and 55 out of every 1000 elderly (Urban) have some sort of disability such as hearing impairment, poor vision or locomotive impairment. While General Physicians and Specialists are capable of taking care of the many problems ailing the elderly, it is important to develop geriatrics as a specialty in order to provide comprehensive care to the older population. At present, elderly receive multiple lines of treatment for multiple issues and yet there is no one authority to ensure a consistent, wholesome care regimen. Most important but frequently overlooked aspect of their care is their mental health care. With a cultural shift towards nuclear families the emotional, financial and mental support system for the older people is gradually crumbling.

As Healthcare providers, it is imperative that we understand the many maladies affecting our elderly and manage them comprehensively while ensuring that they lead not just a healthy but a dignified and happy life. I am confident that this Geriatric Conclave will further the cause of paving a path towards an elder-friendly medical and social ecosystem.

MESSAGE

Dr. N. Subramanian
Sr. Consultant Urologist & Director Medical Services,
Indraprastha Apollo Hospital, New Delhi

I am delighted to learn that the Geriatrics society of India and the Apollo hospitals are organising the Geriatrics conclave. With over 100 million Indians being over 60 years of age and with these figures expected to rise to 15 percent of the population in the next decade, Geriatrics assumes a great significance.

We are all aware that the rising incidence of non communicable diseases with their attending complications is further compounded by the physical limitations, cognitive impairment and frailty, especially in those over 75 years of age.

You have been a pioneer in this field both as a clinician and as an author, drawing attention to special needs of this group. We look forward to applying the lessons learnt to improve the treatment and care of the elderly.

Best wishes

MESSAGE

Dr. P.S. Shankar
Patron
Geriatric Society of India

GERIATRIC HEALTH CARE

The number of elderly is rising all over the world including India. The population of elderly persons in our country is around 90 million. It 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. However it is pathetic to see many of them are not cared. The elderly is living in a private Universe of physical weakness and mental decay.

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. In advancing years many age-related disabilities begin to appear, and they require special medical attention. At the same time we must remember that 'there are no diseases of the aged, but simply disease among the aged'.

Our aim is to take care of them through separate clinics and hospitals catering to the needs. If it is done with all seriousness the old age becomes a happy state in the life of every individual.

We have to extend our activities by encouraging establishment of Geriatric clinics in Multi-specialty Hospitals, and Medical College Hospitals. We have to organize health camps to sensitize and educate people. The subject of Geriatrics has now acquired an increasing special significance which calls for a greater attention by the medical fraternity.

In this backdrop, the Geriatric Society of India is holding ***Geriatrics Conclave*** *in New Delhi and I welcome all persons interested in this subject.*

MESSAGE

Dr. V.K. Arora
Senior Consultant – Respiratory Diseases
Executive Editor- Indian Journal of Tuberculosis
Vice-Chairman (P &R) and Hony. Technical Adviser,
Tuberculosis Association of India

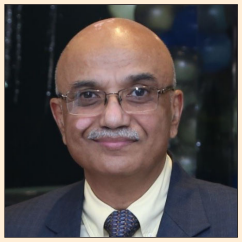
I am delighted to learn that the Geriatric Society of India is organizing "Geriatrics Conclave" in April 2019 in Delhi. With Geriatric population above 60+ in India crossing 120 million marks and is expected to grow to 173 million by 2025. With changing times the concept of joint families, especially amongst the urban population, has almost vanished. In this scenario the care of the aged is a matter of grave concern.

For about two decades now the concept of "Old Age Homes" have gained some momentum but the availability of such facility in India, is still a luxury. Only a fraction of geriatric population can avail of this facility.

The Geriatric Society of India has done commendable work towards care of the elderly and the organization of such a conference definitely will go a long way in achieving good tangible results.

I wish the conclave all the success.

MESSAGE



Dr. Vivek Handa
Chairman

Dr. O. P. Sharma
Organizing Secretary

Dear Colleagues

The population of Elderly (60 years +) is rising worldwide, including in India on account of demographic transition leading to their increased numbers. Presently, it is at around 8.5% of our population. The absolute numbers become huge given the size of our population. Their predominantly rural distribution; absence of structured social security mechanisms, makes their care very challenging both, socially and medically.

Geriatrics is emerging as an important field in medical care. Research and recent developments in this field have given us newer insights into care of the elderly with focus on their special needs; atypical presentations and so on and so forth, with focus on making the interventions safer.

Geriatric Society of India, an NGO has been advocating the cause of the elderly, sensitizing the medical and para-medical fraternity regarding the newer practices for the care for the elderly as a distinct group, through local, Regional, National and International Conferences and meetings.

Apollo Hospitals, Delhi, has taken the leadership role in establishing and providing focussed Geriatric care to its patients in the corporate sector.

The 'Geriatric Conclave' being organized by the Apollo Hospitals and Geriatric Society of India on 20th and 21st April, 2019 will provide a great platform to learn regarding care for this special group. Considerable planning has gone into the structure of the scientific program for the event and efforts have been made that it provides a comprehensive overview of problems seen in the elderly. In this regard, the conclave would facilitate exchange of information into newer insights for better management of the various conditions encountered in elderly.

The participating faculty has been drawn from the experts in their respective fields, with an orientation/passion for care of the elderly. We are sure they will do full justice, befitting their stature, towards fruitful deliberations and practical take-home message for the delegates.

We invite you to participate in this scientific fiesta. Let us share our passion for care of this group of people. We are sure the opportunity will stimulate exchange of views and leave all of us enriched.

We once again welcome you to the Conclave.

Scientific Programme

Geriatrics Conclave 2019

20-21 April 2019, Indraprastha Apollo Hospitals, Sarita Vihar, New Delhi-110076

Time	Day -1- Auditorium Topic	Speaker	Saturday, 20-April 2019 Chair Persons
08:00 AM - 08:30 AM	**Spot Registration**		
08:30 AM - 09:30 AM	Free Papers		Dr. Anil K. Manchanda
09:30 AM - 09:55 AM	Pre-Operative Assessment	Dr. Pratibha Pereira	Dr. Anand P. Ambali Dr. Satish Gulati
	Heart Failure Update		
09:55 AM - 10:20 AM	In Hospital Initiation of ARNI	Dr. K. K. Saxena	Dr. Rakesh Gupta Dr. G. D. Ramchandani
10:20 AM - 10:45 AM	Heart Failure in Diabetes Mellitus	Dr. Sunil Modi	
	Novel Therapies in Diabetes		
10:45 AM - 11:40 AM	Diabetes - Time to bell the Cat	Dr. S. K. Wangnoo	Dr. Rajesh Marya Dr. Meena Chhabra
	SGLT2 & DPP4 Perfect Partners for Wholistic Management of T2DM	Dr. A. Siddiqui	
11:40 AM - 12:10 PM	**Guest Lecture:** CARF A New Regulator of Stress, Aging and Cancer: Evidence from in vitro Stress Models	Dr. Renu Wadhwa	Maj. Gen. L. R. Sharma Dr. O. P. Sharma
12:10 PM - 01:15 PM	**INAUGURATION** **Keynote Address - Ms. Sangita Reddy** **Book Release Function** **Award Session**		
01:15 PM - 02:00 PM	**LUNCH**		
02:00 PM - 02:20 PM	Osteoporosis - Orthopaedic View	Dr. Harsh Bhargava	Dr. Rakesh Kumar Dr. Girish Khurana
	Nutritional Interventions		
02:20 PM - 02:45 PM	Nutrition in Health & Sickness	Dr. Randhir Sud	Dr. Rakesh Gupta Dr. Anita Jatana
02:45 PM - 03:05 PM	Vitamin D - A Vital Hormone	Dr. K. Hari	
03:05 PM - 03:30 PM	**Guest Lecture:** Frailty	Dr. P. S. Shankar	Dr. D. K. Hazra Dr. Ashok Jhingan Dr. R. S. Gupta
03:30 PM - 03:55 PM	Osteoarthritis	Dr. Raju Vaishya	Dr. J. M. Dua Dr. A. S. Arora
03:55 PM - 04:20 PM	COPD - Current Management	Dr. Puneet Khanna	Dr. H. K. Raogupta Dr. K. Anupama Murthy
04:20 PM - 04:45 PM	OHA - Newer Insights in Sulfonylurea	Dr. Atul Luthra	Dr. Sandeep P. Tamane Dr. Vipul Gupta
04:45 PM - 05:55 PM	**Symposium on Care**		
	Palliative Care	Dr. K. B. Linge Gowda	Dr. Ratna Rao Dr. Anand P. Ambali Ms. Geetanjali Kochar Dr. Nikhil Sarangdhar
	Pain Management	Dr. G. P. Dureja	
	Nursing Care	Ms. Gracy Philip	
	Physiotherapy	Dr. Seema Grover	
05:55 PM onwards	**HIGH TEA**		
07:00 PM - 08:30 PM	**CULTURAL PROGRAM**		
08:30 PM onwards	**DINNER**		

Scientific Programme

Time	Day -2- Auditorium Topic	Speaker	Sunday, 21-April 2019 Chair Persons
	Symposium on Falls		
09:00 AM - 09:20 AM	Seniors Friendly Technology	Dr. S. V. Kulkarni	Dr. Kauser Usman Dr. Mohit Saran
09:20 AM - 09:40 AM	Falls - A Gateway to Morbidity	Dr. Nagesh Kavi	Dr. Agam Vora Dr. Vivek Handa
09:40 AM - 10:05 AM	Adult Vaccination	Dr. Anil K. Manchanda	Dr. A. K. Prasad Dr. M. S. Chaudhary
10:05 AM - 10:35 AM	**Guest Lecture:** Ashwagandha for Interventions of Aging and Age-related Pathologies: Experimental Evidence	Dr. Sunil Kaul	Dr. P. S. Shankar Dr. Atul Kulshrestha Dr. Padmamalika Khanna
10:35 AM - 11:00 AM	Dementia - Parkinsonism Overlap/Combination	Dr. P. N. Renjen	Dr. Atulya Saurabh Dr. Garima Handa
11:00 AM - 11:25 AM	Urinary Incontinence in Elderly	Dr. Rajesh Taneja	Dr. S. K. Agarwal Dr. Amit Gupta
11:25 AM - 11:45 AM	ABC of Geriatrics	Dr. Anand P. Ambali	Dr. M. S. Gudi Dr. Naveen Kulkarni
11:45 AM - 12:10 PM	Tuberculosis - Reactivation/Reinfection	Dr. Agam Vora	Dr. V. K. Arora Dr. Ruchi Manchanda
	Symposium on Haematology		
12:10 AM - 12:30 PM	Anaemia	Dr. Sudhir Mehta	Dr. P. S. Sarma Dr. Harsh Dua
12:30 PM - 12:50 PM	Interpretation of Lab Values	Dr. A. K. Singh	Dr. Sangeeta Rawat Dr. Dheeraj Kapoor
12:50 PM - 01:35 PM	**CONVOCATION**		
01:35 PM - 02:15 PM	**LUNCH**		
02:15 PM - 02:40 PM	**Panel discussion - Corporate Initiatives in Geriatric Care**	Dr. O. P. Sharma Dr. Syamasis Bandyopadhyay Dr. Suddhasatwya Chatterjee Dr. Rajendran Magesh Dr. Senthil Kumar Dr. Bijay Kumar Patnaik Dr. Ch.Vasanth Kumar	Maj. Gen. Jagtar Singh Dr. Ratna Rao
	Symposium on Safer Drugs		
02:40 PM - 03:05 PM	Safer Antibiotics	Dr. Prabha Adhikari	Dr. Saurabh Srivastava Dr. Sajesh Asokan
03:05 PM - 03:25 PM	Safer Insulins in Elderly	Dr. J. K. Sharma	Dr. Sandeep P. Tamane Dr. Vipul Gupta
03:25 PM - 03:45 PM	Experience with Weekly GLP1 RA	Dr. S. K. Wangnoo	Dr. Amitesh Aggarwal Dr. Suriadeep Sengupta
03:45 PM - 04:05 PM	Renal Impairment in Hyperglycaemia	Dr. Gaurav Sagar	Dr. Ashok Sarin Dr. V. K. Aneja
04:05 PM - 04:30 PM	Stroke	Dr Vinit Suri	Dr. B. C. Bansal Dr. Satnam Chhabra
04:30 PM - 4:50 PM	Spinal Problems in the Geriatric Population	Dr. H. N. Bajaj	Dr. Harsh Rastogi Dr. Manoj Kumar
4:50 PM - 05:10 PM	**VALIDICTORY**		
5:10 PM onwards	**HIGH TEA**		

Faculty Photos

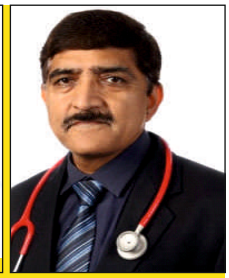

Dr Anil Manchanda


Dr. Anand P. Ambali

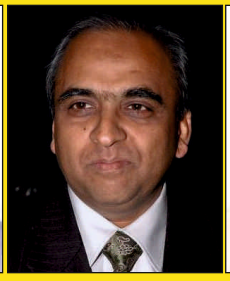

Dr Satish K Gulati


Dr Pratibha Pereira


Dr Rakesh Gupta


Dr. G.D.Ramchandani


Dr KK Saxena


Dr. Sunil Modi


Dr. R K Marya


Dr. Meena Chhabra


Dr. Subhash K.Wangnoo


Dr. Mohammad Asim


Maj Gen.(Dr.) L.r.sharma


Dr. OP Sharma


Dr. Renu Wadhwa


Dr Rakesh Kumar

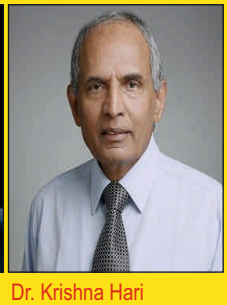

Dr Girish Khurana


Dr Harsh Bhargava


Dr Rakesh Gupta


Ms Anita Jatana


Dr Randhir Sud


Dr. Krishna Hari


Prof Daya Kishore Hazra


Dr Ashok Jhingan

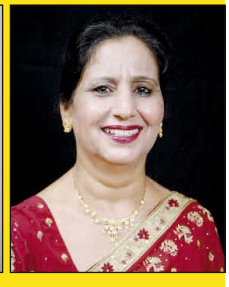

Dr R. S. Gupta


Dr PS Shankar


Dr JM Dua


Dr As Arora


Dr. (Prof.) Raju Vaishya


Dr HK Raogupta

Faculty Photos


Dr.K. Anupama Murthy


Dr Puneet Khanna

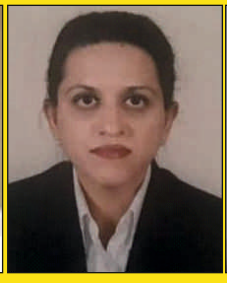

Dr. Sandeep P. Tamane


Dr Vipul Gupta


Dr. Atul Luthra


Dr. Ratna Rao


Dr. H.N. Bajaj


Dr Geetanjali Kochchar


Dr. Nikhil Sarangdhar


Prof. Lingegowda. K.B.


Dr GP Dureja


Ms. Gracy Philip

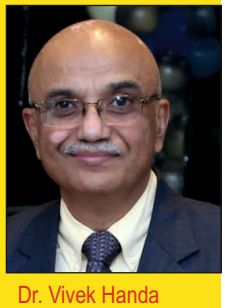

Dr Seema Grover, PT


Dr. Kauser Usman


Dr. Mohit Saran


Dr. SVKulkarni


Dr Agam Vora


Dr. Vivek Handa


Dr Nagesh G Kavi


Prof. AK Prasad


Dr MS Chaudhary


Dr. Atul Kulshreshta


Dr Padmalika Khanna


Dr. Sunil Kaul


Dr. Garima Handa


Prof. PN Renjen


Dr SK Agarwal


Dr Amit Gupta


Dr Rajesh Taneja


Dr MS Gudi

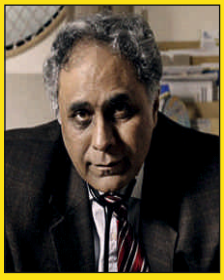
Faculty Photos


Dr Naveen Kulkarni


Dr VK Arora


Dr Ruchika Manchanda

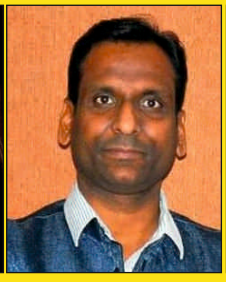

Dr PS Sarma


Dr. Harsh Dua


Dr Sudhir Mehta


Dr. Dheeraj Kapoor


Dr. A.K. Singh


Dr. Saurabh Srivastava


Dr. Sajesh Asokan


Dr. Prabha Adhikari


Dr. Jugal Kishor Sharma


Dr. Amitesh Aggarwal


Dr. S. Sengupta


Dr Ashok Sarin


Dr. VK Aneja


Dr Gaurav Sagar


Dr BC Bansal


Dr Satnam Chhabra


Dr Vinit Suri


Dr. Harsh Rastogi


Dr. Manoj Kumar Ch

Dr Sangeeta Rawat

Abstracts Geriatric Conclave

Ashwagandha for Interventions of Ageing and Age-related Pathologies: Experimental Evidence

Sunil Kaul

Ashwagandha (*Withania somnifera*) is a tropical herb that enjoys more than 5000 years of history of use in Indian home medicine 'Ayurveda'. Although it is extensively used to promote physical and mental health, molecular mechanism of its action is not clearly understood. We first identified selective cancer cell killing activity in the alcoholic extract of Ashwagandha leaf extract (i-Extract). By combined chemical and cell-based loss-of-function screenings using human siRNA and randomized ribozyme libraries, we reported that the i-Extract and its component 'withanone' kill cancer cells by mechanisms including selective activation of (i) tumor suppressor protein p53 and (ii) ROS signaling in cancer cells. Similar to the alcoholic extract, water extract was shown to possess anticancer activity that worked through activation of tumor suppressor pRB providing support to the holistic approach recommended in Ayurveda. We have discovered bioactivities in the leaf extract of Ashwagandha that protect the normal cells against a variety of stresses and contribute to Quality of Life. These include differentiation of brain-derived cells during stressed conditions including oxidative environment, amnesia and glutamate excitotoxicity. Consistent to these findings, i-Extract showed protective effect in chemically-induced mouse model of Parkinson's disease. i-Extract and withanone treated normal human fibroblasts showed extended lifespan and protection against industrial toxin, MAA. These findings demonstrate that Ashwagandha has potential to intervene age and age-related diseases including cancers and neurodegeneration.

DBT-AIST International Laboratory for Advanced Biomedicine (DAILAB), National Institute of Advanced Industrial Science & Technology (AIST), Tsukuba Science City - 305 8565, Japan

E-mail: s-kaul@aist.go.jp

Increase in Ageing Population and Age-related Pathologies: Herbal Solutions (focus on Ashwagandha)

Sunil Kaul and Renu Wadhwa

Human life expectancy has improved significantly over the last 3-4 decades resulting in a remarkable concerning trend of increase in ageing population in most developed countries. The global aged population is currently at its highest level in human history and expected to grow rapidly in next decades due to decrease in birth rate. It is predicted that the combined senior and geriatric population will reach 2.1 billion by 2050. Such changes in population demographics have raised several challenges and alerts for health care systems. There is increasing and urging need to find NEW (Natural Economic & Wellfare) therapeutic solutions to old age pathologies and sustain (QOL) Quality Of Life especially at later years of life.

Over last ten years, we started with screening of disease therapeutic and health promoting natural compounds from several herbs by recruiting experimental strengths in biotechnology and molecular biology. Our first focus was on Ashwagandha (*Withania somnifera*), a popular herb used in traditional Indian home remedies over thousands of years. We identified anticancer activity in the leaves of Ashwagandha and demonstrated its mechanism of action by multiple experimental and bioinformatics approaches. We reported that the anticancer ingredients of Ashwagandha may be recruited for treatment of complicated cancers that do not respond to conventional drugs such as telomerase inhibitors. Furthermore, we found that the low doses of active ingredients possess anti-stress properties that could be recruited for old age associated brain dysfunctions. In view of these findings, we initiated to develop technologies to obtain Active Ingredients Enriched (AIE=i) Ashwagandha by manipulating its growth conditions. We demonstrated (i) field raised i-Ashwagandha leaves with high proportion of active withanolides as compared to the roots, (ii) cultivation conditions to improve the leaf yield in field, (iii) hydroponic cultivation and iv) extraction method to obtain enriched bioactives for use in disease therapeutics and health care.

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6. Yu Y., *et al.* (2019) *Oncol Rep.* (in press).

DAILAB, DBT-AIST International Center for Translational & Environmental Research (DAICENTER), National Institute of Advanced Industrial Science & Technology (AIST), Tsukuba 305-8565, Japan

E-mail: s-kaul@aist.go.jp

CARF (Collaborator of ARF): A New Regulator of Stress, Ageing and Cancer

Renu Wadhwa

CARF was discovered in our laboratory as a novel ARF-binding protein. It was shown to interact with p53-tumor suppressor and HDM2 proteins, and regulate p53-HDM2-p21 pathway in two directions in a dose-dependent manner. Whereas CARF upregulation resulted in growth arrest (as seen in stressed and senescent cells), its super-high level of expression led to aggressive malignant transformation of cancer cells. Suppression of CARF, on the other hand, triggered apoptosis suggesting that it is an essential cell survival protein and could serve as a target for cancer therapy. Indeed, amplification of CARF (both at gene and transcript levels) was found in a variety of invasive and metastatic malignancies. Consistent to these clinical readouts, CARF-enriched cells showed enhanced epithelial-mesenchymal transition (EMT), and its silencing caused strong tumor suppression and inhibition of metastasis. A variety of environmental stresses were seen to affect CARF protein, that could be used as a marker to predict the fate of cells to stresses. Using cell immortalization as a model, we demonstrate that the stresses causing strong upregulation of CARF indeed caused malignant transformation of cells predicting it to be reliable marker and regulator of proliferation fate of cells, and a novel molecular bridge between aging and cancer.

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DBT-AIST International Laboratory for Advanced Biomedicine (DAILAB), National Institute of Advanced Industrial Science & Technology (AIST), Tsukuba Science City 305-8565, Japan

E-mail: renu-wadhwa@aist.go.jp

Physiotherapy in Geriatrics

Seema Grover

In India there has been a surge in elderly population due to improved health services. The elderly population has increased from 12.5 million in 1951 to 97 million in 2017.

Normal effects of ageing are reduced bone density, reduced muscle strength, increased body fat, poor coordination and stiff joints leading to poor mobility, balance and falls. Other common problems are poor vision, anaemia, hypertension, diabetes, cognition, hearing, incontinence and psychological issues. World Health Organization (WHO) promoted a concept healthy ageing that considers the ***ability of people of all ages to live a healthy, safe and socially inclusive lifestyle.*** Rehabilitation in elderly is a multidisciplinary approach keeping patient and care giver at the focus with a goal to provide elderly more meaningful & dignified life.

Physiotherapists have a key role in enabling older people to use the body's systems fully to enhance mobility and independence. Physiotherapist assesses impairment - disability, does goal setting and helps elderly to improve strength,

balance, coordination, flexibility and pain levels. Few outcome measures are elderly mobility scale, SF-36 quantify the change.

Physiotherapeutic management includes the development of motor programmes for enhancing and ensuring optimal utilization of their preserved abilities and providing necessary assistance to achieve maximum level of function to improve quality of life.

Abstract of the topic FALLS

Nagesh

A fall is one of the most common events threatening the independence of older adults. A fall is considered to have occurred when a person comes to rest inadvertently on the ground or lower level. Most of the literature on falls excludes falls associated with loss of consciousness. Falls are generally multifactorial in origin, with complex interactions among intrinsic risk factors (age-related declines, chronic disease, medications), challenges to postural control (environment, changing position, routine activities), and mediating factors (risk-taking behaviours, situational hazards, acute illness). Older adults with even a single fall should have a gait and balance evaluation. For older adults with two or more falls in the past 12 months, or with gait or balance abnormalities, a multifactorial falls risk assessment should be pursued. Important components of a fall history include the activity of the patient at the time of the fall, the occurrence of prodromal symptoms such as dizziness and imbalance. Interventions shown to be effective in reducing falls include medication review, exercise programs that include muscle strengthening and balance training, vitamin D supplementation, use of appropriate footwear, and multifactorial interventions including home hazards assessment for those at high risk of falls.

The Role of Vitamin D to Prevent Falls- Geriatric Care Perspective

K Hari

Falls are one of the major problems in the elderly and are considered one of the “geriatric Giants”. Falls represent the commonest accident of daily living and are the leading cause of Accidental death in the elderly. The prevalence of vitamin D insufficiency is estimated between40% and 50% in non-fallers over the age of 65 and up to 70% in fallers. Vitamin D Supplementation of at least 700 iu per day might reduce the risk of falls amongst older adults by 19%.

ABC of Geriatric Care

Anand P. Ambali

Introduction: The ABC of care of older people aims to improve quality of life, prevent disabilities and provide dignified death. The assessment of older people take place at Out -patient and In-patient clinic, emergency set up, for pre-operative fitness and home visit for those who are bed ridden.

ABC of care: The clinical approach to the older people differ from that of the younger people in terms of Atypical presentations, denial of illness, part of ageing, silent presentations, multiple comorbidities, difficult to decide which symptoms to inform and physicians attitude towards older people.

The behaviour pattern among elderly people when develops acute diseases which leads to decreased Quality of life and the way the diseases affects the elderly varies.

The most important factor that plays vital role in successful consultation is Communication. The success of the clinical encounter and management plans depends upon communication skills applied. The issues like decreased hearing, poor vision, decreased concentration need to be addressed before a clinical examination is initiated. The clinicians should always know the care giver of the patient and also take history from the care givers. The care givers should be trained to do common procedures like recording blood pressure, use of glucometer and oral care. They should also be screened for burnt-out periodically and Respite care should be provided to them.

The special attention is required to address Dementia, Disabilities, Drug Abuse, Depression while providing care.

The Functional status is assessed by scales like Activity of Daily Living(ADL), Instrumental Activity of Daily Living(IADL), Mini Nutritional Assessment(MNA). The follow Up of older people with chronic non- communicable diseases should be

made mandatory in view of preventing the complications.

An empathetic approach to the older people is need of the hour. The clinicians should avoid ageism attitude.

The End of Life Care(ELC), Medical will, Body donation, Hospice care, Eye Donation and Allow Natural Death(AND) issues need to be initiated with the older person as well their family members on the day of diagnosis of terminal illness.

The care models like palliative care and rehabilitation was once reserved for malignancy. Now, these modalities are recommended for diseases like Alzheimer's and Chronic Obstructive Lung Diseases. The role of Palliative care and rehabilitation begins on the day of diagnosis of terminal illness.

The older people need to be screened for Communicable diseases, Diabetes, Hypertension, Thyroid disorders, Depression, Dementia, Malignancy, Polypharmacy, Cataract, Hyperlipidaemia and complications of existing non-communicable diseases periodically.

The role of clinician in education regarding preventable diseases like pneumonia and vaccines availability and Falls is vital.

The social issues like Elder Abuse, Loneliness and economic situation needs to be considered while dealing with older people.

The role of physiotherapy is required in older people especially undergoing replacement surgeries apart from chronic diseases like cervical spondylosis and fracture neck of femur. The availability of assistive devices need to be incorporated while providing care.

Conclusion: A holistic approach in clinical scenario to the older people is need of the hour.

Pre-operative Assessment

Pratibha Pereira

Definition: In the past, say up to 1980, higher mortality resulted in reluctance to operate on elderly performed only urgently or emergent leading to even poorer outcome. However change in attitude towards estimation of surgical risks has lead to Improvement in anesthesia and surgical expertise. This has led to decline in mortality. Therefore Surgery can no longer be denied on the basis of age alone. Pre op assessment in elderly is complex and difficult as Ageing is a progressive physiologic process. Common diseases of elderly patients may have a major impact on anesthetic management and require special care and diagnosis are cardiovascular disease and diabetes. The decision to operate must not be based on age alone but should reflect an assessment of the risk to benefit of individual cases particularly with comorbid conditions.

Incontinence in Geriatric Population

Rajesh Taneja

Incontinence of Urine is defined as involuntary loss of urine. This is a particularly troublesome not only for the patient but also for the whole family. The impact of this problem is compounded by low self-esteem, withdrawal from social circle, and embarrassment in the presence of family members leading to a depressed individual.

Incontinence can be of following types:

1) ***Urge incontinence***: The patient has an intense desire to pass urine and before he/she can reach a socially acceptable place to ease, there is leakage of urine, which could vary from few drops to a large volume. Usually this could occur due to urinary infection, Overactive bladder and Benign Hyperplasia of Prostate. These patients respond to Anticholinergic (Tolterodine, Solifenacin, Trospium) and Beta-adrenergic agonist (Mirabegron) agents. In elderly, diseases of CNS like Parkinsonism; subtle infarcts in prefrontal cortex, paraventricular areas, basal ganglia and brain stem can cause Detrusor Hyperreflexia, which clinically presents as Overactive bladder. Quite often these lesions go unrecognized and on radiological evaluation are reported as "age related non specific ischemic changes". These patients do not respond to usual treatment modalities used for Overactive Bladder and are really difficult to manage.
2) ***Overflow incontinence:*** This is a paradoxical situation where the bladder is unable to empty itself and remains full to its capacity. The urine escapes with minimal urge or stress. Stress incontinence in elderly male who hasn't got any history of surgery in urinary tract is likely to be due to Overflow incontinence. Treatment involves clearing of the cause of obstruction.

3) ***Stress incontinence:*** This is loss of urine on abdominal straining and is a common cause of incontinence in elderly women. This can be treated with exercises, and surgical strengthening of the perineal floor.
4) True incontinence may occur in elderly population due to true paralysis of the skeletal sphincter secondary to trauma, surgery and CNS affliction.

Safer Insulin in Elderly

S.K. Wangnoo

The prevalence of type 2 diabetes is increasing among elderly. Although many individuals with type 2 diabetes mellitus will ultimately require insulin therapy to achieve and maintain glycaemic control, early insulin initiation in elderly population can be considered, especially in those with renal, cardiovascular, or hepatic impairment that could interfere with the use of oral agents. Insulin therapy in older patients can be difficult to manage. The risks of this high-alert medication include hypoglycaemia, and therapy often is complicated by multiple comorbidities, polypharmacy, vision impairment, poor mobility and dexterity, neuropathies, and cognitive impairment. The use of basal insulin analogues (e.g. detemir and glargine) with relatively little peaking effects has made insulin therapy in elderly subjects a relatively straightforward process. Insulin analogs (e.g. Lispro, aspart, glulisine) offer a better pharmacokinetic profile, greater convenience, and less variable glycaemic control than human regular insulin. Insulin pens offer greater simplicity, flexibility, and convenience than traditional vial and syringe administration, and features such as audible pen clicks and high dosing capacity help patients who have visual impairments, high insulin requirement and overall ease of use can help patients who have impairments of capability. Insulin pump can also be a good option for elderly population but cost can be a hindrance for this. Diabetes educator team should counsel patients on hypoglycaemia recognition and management as well how to store, titrate dose, and proper insulin administration.

Vaccination in Elderly Population

Anil K Manchanda

As we get older, our immune system weakens. Therefore elderly people particularly of more than 65 years of age are vulnerable to communicable diseases like flu (including Swine flu, Bird flu etc), pneumonia, Hepatitis and shingles — and to have complications that can lead to long-term illness, hospitalization, and even death. If there is an ongoing health condition — like diabetes, heart disease, COPD/ACOS, CKD, CLD or other Immunocompromised state getting vaccinated is especially important. Vaccines can protect us from serious diseases (and related complications) so we can stay healthy as we age. In October 2017, the Advisory Committee on Immunization Practices (ACIP) USA voted to approve the Recommended Immunization Schedule for Adults after in-depth reviews of vaccine-related data, including disease epidemiology, vaccine efficacy and effectiveness, vaccine safety, feasibility of program implementation, and economic aspects of immunization policy. Similarly recommendations by Indian Guidelines For Vaccination in Older Adults, API, and WHO have also been incorporated to address this issue.

CKD in Geriatrics

Gaurav Sagar

Prevalence of end-stage renal disease (ESRD) in elders is notably higher; approx one-third of chronic kidney disease patients are aged above 65 years. Elderly population with CKD is associated with increased morbidity and mortality. The body of knowledge on the approach to elderly patient with CKD is still evolving. Generally risk factors for CKD in elderly population are Hypertension, Diabetes, Obesity, Proteinuria, Hyperlipidemia, Cardiovascular disease, Glomerular and tubulointerstitial disease, Metabolic acidosis, Smoking & High-protein diet. Diagnosing the renal disease and its management in elder population is a challenge because of heterogeneous nature of this population; co-morbidities and ageing process further complicates the diagnosis as well as the treatment. Treatment of CKD in the elderly has to be individualized and should be in favor of patient's perspective, which may prioritize quality of life over prolonging life. They should be given all

the available treatment option. There is limited information for evidence-based guidelines and recommendations for managing CKD in the elderly. The frequent use of complex medication regimens and multiple medications with limited clinical data available on drugs; treatment decisions will ultimately require a balance of risks and benefits, together with patient goals. The decision-making process should involve multiple perspectives: patient, caregiver/family, treatment in conjunction with the geriatrician-nephrologist collaborative team.

Geriatric palliative care

KB Linge Gowda

India is categorised as a developing country and it has the second largest population in the world; however over the past 20 years, increases in the ageing population and prevalence of advanced cancer are common.

It is estimated that in India a total number of population who need palliative care is more likely to be 6 million a year.These figures are likely to grow because of increasing life span and a shift from acute to chronic illness.

According to WHO, there were 60 million people above 65 years of age in 2010 in our country and that this figure will increase to 227 million by 2050. The caring for these people at home will place an unacceptable burden on families while hospital stays will be costly and beyond the reach of most people.

Geriatrc palliative care that is patient focussed and family oriented and that is preferably delivered at home. Illness and disability in the geriatric population will require special health services while their unique psychosocial needs and concerns will require a wider societal response. They will require long term care which can become a burden for families and lead to their neglect and abuse.

Palliative care must become a part of the public health delivery system as only then we will be able to care for our elders with the love and respect they deserve.

Osteoporosis

Harsh Bhargava

Osteoporosis is the largest disease of the world but confirmed & known patients who are suffering from this in whole population is like seeing the tip of an iceberg in an ocean. The patient usually falls; in lap of Orthopaedic surgeon after a fragility fracture sets in commonest of fractures are in spine (vertebral column fracture or VCF) & other common areas are hip, wrist & ankle. As an Orthopaedician, one should show comprehensive approach for osteoporosis like –

- Confirm the diagnosis by DEXA SCAN
- Treat the fracture
- Prevent incidence of second fracture
- Impose life style change
- Medical management to reverse osteoporosis.

We are supposed to guide patient's rehabilitation with help of physiotherapist & occupational therapist.

As majority of patient suffering from osteoporosis are elderly and likely to suffer from other co-morbidities like diabetes, COPD, IHD, poor renal functions, the treatment should be tailor-made and optimal rather than aggressive or so called ideal.

A lot of developments have taken place in last couple of decades in the treatment modalities which includes cementing in spine like Vertebroplasty & Kyphoplasty. Special changes in fracture fixation devices is happening – Specialized nails, Locking with helical blade,Locking metaphyseal & diaphyseal plates.

The changes are helping us to produce better results in fracture stabilization with early functional recovery.

Dementia – Parkinsonism Overlap

P N Renjen,[1] Dinesh Chaudhari[2]

Alzheimer's disease (AD) and Parkinson's disease (PD) are the two most common neurodegenerative disorders in humans. They are characterized by insoluble protein deposits; α-amyloid plaques and tau-containing neurofibrillary lesions

in AD, and α-synuclein-containing Lewy bodies in PD. Dementia occurs in up to 30% of people with Parkinson's disease and is a major cause of disability. Pathologically, Parkinson's dementia, where dementia follows the onset of parkinsonism by at least one year, overlaps with dementia with Lewy bodies. Both PD and other disorders causing parkinsonism can be associated with dementia and cognitive impairment. Dementia can be defined by the presence of an acquired cognitive disorder, affecting two cognitive domains (i.e., among memory, language, praxis, visuospatial function and executive function), leading to a decline in activities of daily living. Tauopathies with dementia and parkinsonism represent a group of disorders with shared underlying pathology of intracellular accumulation of tau protein. Classical clinical features can help distinguish these disorders, but there is often marked overlap of clinical features. The overlapping clinical and pathological features render clinicians at a disadvantage in diagnosing and counseling patients with a variety of parkinsonian disorders associated with dementia.

Asthma - COPD overlap: A management dilemma

Dr Puneet Khanna

Many elderly patients traditionaly diagnosed with asthma and chronic obstructive airway disease (COPD) often have overlapping clinical presentation that makes it difficult to manage them as per established treatment guidelines of asthma or COPD. This subset of patients are now acknowledged as a distinct phenotype as ***Asthma-COPD-Overlap*** (ACO). Recognition of ACO has important therapeutic implications as these patients have frequent exacerbation, use more medications, and have greater morbidity and poorer quality of life.[3] There are currently no universally accepted, validated criteria to diagnose ACO. Guidelines recommend a stepwise approach to the diagnosis while using clinical, spirometric and radiographic findings to include those suffering from asthma or COPD and fulfilling enough common features to be considered as ACO. The exact prevalence of ACO remains unknown though it has been shown that the frequency of ACOS increases with advancing age, with an estimated prevalence of >50% in patients aged 80 years or more. The GINA–GOLD document suggests that initial strategy in the case of ACO should be to start treatment as per asthma pending further investigations and recommends LABA/ICS combination followed by triple therapy. Even though ACO demonstrates indistinct clinical and pathophysiological features to those of asthma or COPD, early recognition is essential for optimal management strategey.

COPD: current perspectives

Puneet Khanna

COPD is a common, preventable and treatable disease characterized by persistent respiratory symptoms and airflow limitation due to airway and/or alveolar abnormalities usually caused by significant exposure to noxious particles or gases. The persistent airflow limitation is usually progressive with variable chronic inflammatory response. Exacerbations and comorbidities contribute to the overall severity. It is a major respiratory cause of chronic morbidity and mortality in the elderly, and is the second biggest cause of death in India with the prevalence ranging between 2 to 22% among the men and 1.2 to 19% among women. In addition, it has a huge social and economic impact on quality of life. Risk factor for COPD include tobacco smoking along with vehicular emissions from biomass fuels, *chulha* smoke in villages, industrial chemicals or construction dust. Major symptoms are progressive dyspnea, chronic cough, and/or sputum production. The goals of COPD management are to determine the severity of the disease, including the severity of airflow limitation; the impact on the patient's health status; and prevent exacerbations, hospital admission, or death. Spirometry testing remains the cornerstone of diagnosis and classifying the severity of disease. The mainstay of COPD treatment remains long-acting anti-muscarinic agents and beta2-agonists. Prompt diagnosis, appropriate pharmacologic therapy and preventive strategies include vaccinations can effectively reduce COPD symptoms.

Digital Technology in Geriatric Health: A concise review

S.V. Kulkarni[1], Sagar Sinha[2], Priyanka Jadhav[3], Chitra S Kulkarni[1]

There is a significant growth in the elderly population in the world. The challenges of geriatric healthcare are easily noticeable in developing countries like India. Fortunately, technology has grown by leaps and bounds in the last few decades. The digital techno-bubble is still growing rapidly with recent emphasis on e-health. A lot of investment is being done in this field to develop the end-product: a mobile application (app) or add-on-device (peripheral). Various platform integrations have allowed for better connectivity and improved accessibility. Solutions are available for all aspects of healthcare. Geriatric medicine needs to quickly adapt some of these low-cost solutions which can only result in a positive influence on outcomes: clinical end-points of disease management, self-management, greater independence without increasing reliability or compromising safety and other global health issues.

1. Director: Diaabetter, Center for Diabetes, Thyroid, Obesity & Adolescent Research, Navi Mumbai
2. Intensivist & Assistant Professor, Emergency Medicine, MGM Medical College & Hospital, Navi Mumbai
3. Assistant Professor, General Medicine, DY Patil School of Medicine & Hospital, Navi Mumbai

Anemia in the Elderly

Sudhir Mehta

Anemia is common among elderly and is associated with increased morbidity and mortality in this vulnerable age group. Recent population-based surveys have renewed the debate and ascertained the rising prevalence of anaemia in elderly to be a "public health crisis". Anemia hampers functional capacity and cognition, increases risk for frequent falls, frailty, dementia, hospitalization, mortality and mobility and ultimately affects the quality of life.

The causes of anemia also differ from younger population and may be related to polypharmacy and comorbidities. Anemia in elderly is divided in three major types: nutritional deficiency (1/3rd), anemia of chronic disease including chronic renal disease (1/3rd) and unexplained anemia (1/3rd). A high index of suspicion is required to manage anemia in elders. The symptoms (easy fatigue, decrease appetite, pallor) are usually taken as consequences of advance age. The onset of signs and symptoms are insidious and elders adjust their routine activities to the remaining physical capabilities and physiological adaptations. Anemia may present as worsening of associated disorder like worsening congestive heart failure, cognitive impairment, dizziness and apathy.

The evaluation of anemia in elderly involves complete history including dietary, medical illness and medication history and through physical examination to detect any sign suggestive of etiology followed by further investigations accordingly. The reticulocyte haemoglobin equivalent (RET-He) can easily differentiate iron deficiency from anemia of chronic disease. The treatment of anemia depends on its etiology and severity. In severe anemic, red cell transfusion is required along with treatment of underlying etiology. In UA, erythropoietin replacement in higher dose than usual may be needed due to blunted response to erythropoietin. Anabolic steroid supplementation is also beneficial in elderly anemic.

Apollo Geriatric and Elder Care Services (AGES)

Ratna Rao

Demographic Transition: India is undergoing a phase of demographic transition. A report released by the Ministry of Statistics says that the number of citizens over the age of 60 have jumped from 7.6 crores in 2001 to 10.3 crores in 2011 which accounts for 35.5 % increase in the geriatric population. It has been projected that by the year 2050, the number of elderly people would rise to about 32.4 crores.

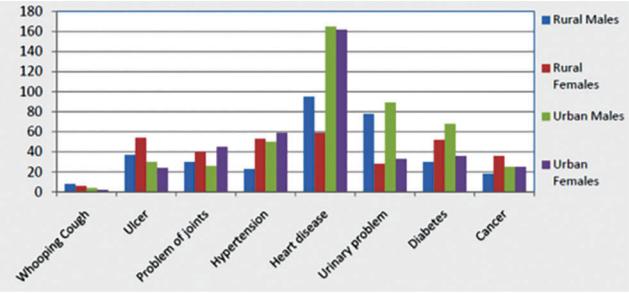
Number of persons aged 60 years and above reporting a chronic disease (per 1,000 persons)

The current statistics for the elderly in India gives a prelude to a new set of medical, social, and economic problems that could arise in the near future.

Growing elderly population is one of the biggest challenge today .Elderly patients seeking medical attention is increasing and account for two third of the inpatients .The need for a dedicated facility to cater to medical, psychosocial aspects of this vulnerable population is increasingly felt in healthcare set up. An organised multidisciplinary team with environment friendly facility contribute to a favourable outcome.

APOLLO GERIATRIC AND ELDERCARE SERVICES (AGES): A comprehensive evidence based elder care program aimed at improving the health, independence and quality of life of older people was established three years ago. AGES was formally inaugurated on 19th JAN 2016 at 5 locations – Bhubaneshwar, Chennai, Delhi, Kolkata, and Hyderabad. Each of the location is taken care of by a geriatrician. These services are in the form of multidisciplinary geriatric care team comprising of Geriatrician, Geriatric nurse, Physiotherapist, nutritionist and as per need other specialists.

The special health check packages for elderly for the purpose of assessment of health status and early detection of ailments are available.



Source - http://www.censusindia.gov.in/2011census/population_enumeration.html

SERVICES OFFERED

A. OP and IP Services

The idea to offer Geriatric services for both out patients & in patients in the institutions was implemented by offering elderly care by a multi-disciplinary team comprising of:

1. Geriatrician; 2. Physiotherapist; 3. Nutritionist; 4. Nurse; 5. Care Manager.

For outpatients, emergency room & inpatients referral criteria were made & geriatric services were commissioned at five locations namely Chennai, Delhi, Hyderabad, Kolkata & Bhubaneshwar

B. Health Checks

To increase the health awareness & the importance of early detection of diseases, two types of health check-ups were designed

A)Apollo Senior Citizens Health Check I basic package (Basic work up)

B)Apollo Senior Citizens Health Check II Extended package(Advanced work up)

C.Vaccination

To prevent the vaccine preventable diseases, the use of vaccination was promoted. As per World Health Organization guidelines, vaccination was promoted for pneumococcal disease & influenza in senior citizens specially in those who had some comorbid condition like COPD, Asthma, Congestive Cardiac Failure, Diabetes Mellitus, Chronic Kidney Diseases, Chronic Liver Diseases, People on Immunosuppressive drugs, Frailty, people with history of obstructive sleep apnoea & susceptible to nocturnal aspirations. Besides these Tdap & Zoster vaccines are also offered

Public Health Activities of AGES

1) Public education

Participation in partnership with Unmukt in events to bring about awareness in healthy ageing. A quarterly E-newsletter has been in initiated.

2) Health awareness

To spread the health awareness among elderly:

a. Health check-up camps are being organized jointly with RWAs.
b. Health awareness talks are being delivered in the senior citizens centres managed by RWAs.
c. Health awareness talks are being delivered in public sectors & corporates.

Apollo Fellowship Program in Geriatrics (AHERF)

The fellowship program in Geriatrics under AHERF will be started at Indraprastha Apollo Hospitals, New Delhi, Apollo Chennai, Apollo Kolkata & Apollo Hyderabad.

d. Two Honorary Fellows at each centre for a duration of one year.
e. The Curriculum will cover Frailty, Immunity, Geriatric Syndromes, Vaccination, Gerio-Pharmacy, ADL, and Nutrition Assessment Scoring & Falls & Gait. The curriculum with other specialities where Fellows will be made in consultation with them.
f. Fellowship will be awarded in a convocation ceremony.

Way forward

We plan to open up this facility in all our centres in the future and contribute to healthy ageing in our population.

FREE PAPERS

COMPARATIVE STUDY OF 3 TESTS OF COGNITIVE IMPAIRMENT (MMSE, AD -8, GPCOG) IN 131 SUSPECTED GERIATRIC CASES OUT OF 2500 SCREENED FOR COGNITIVE IMPAIRMENT

ABSTRACT

In the "Memory Loss Clinic" under Department of Geriatrics, Government Medical College, Aurangabad, regular screening is done with the help of a simple questionnaire (that includes bio-data & recall tests) for suspected cognitive impairment[1] in the patients attending Geriatrics OPD. Of the 2500 patients screened over past 6 months, 131 were suspected to have cognitive impairment and they were subjected to 3 standard tests (MMSE[2], AD-8[2], GPCOG[3]). 51.14% of patients were found to have cognitive impairment by MMSE, 65.64% by AD-8 and 57.25% by GPCOG. The 3 tests have been compared , various parameters of the observations have been subjected to statistical analysis and the results are discussed in this article.

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Dr. Mahesh Patil
PG Resident (JR 1 MD GERIATRICS MCI permitted course),
Department of Geriatrics Government Medical College, Aurangabad

Under the guidance of
Dr. Mangala Sonavani (Borkar)
Professor & HOD, Department of Geriatrics, GMC, Aurangabad.

Dr. Shailaja Rao
Associate Professor, Department off Geriatrics GMC, Aurangabad

FREE PAPERS

COMPARATIVE STUDY OF TWO SCORING SYSTEMS (GDS-4 & GDS-15) USED FOR DETECTING DEPRESSION IN 150 GERIATRIC PATIENTS

ABSTRACT

Depression is a common problem in geriatric patients due to multiple causes.[1] It is measured by a number of scoring systems.

We screened 150 patients for depression with 2 scoring scales [Geriatric depression scale-4 (GDS 4) & Geriatric depression scale -15(GDS 15)]. In GDS- 4, 4 questions are asked, whereas In GDS-15, there are 15 questions.

We observed that by GDS- 4 scale, 44 % of the patients in the study were depressed and when the same patients were interrogated immediately afterwards by using GDS-15 scale, 49.3% patients were found to be depressed. Appropriate statistical analysis suggests that the two scales (GDS- 4 & GDS-15) give comparable results.

The GDS-15 scale recording takes twice the time as compared to GDS- 4. Hence for screening purposes, GDS- 4 scale appears to be adequate, especially in a busy OPD or a health camp.

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Dr. Ashish Rajan
Junior Resident-1(MD GERIATRICS course [MCI permitted])
Dept. of Geriatrics
Govt. Medical College, Aurangabad

Under guidance of
Dr. Mangala Borkar Sonavani
Professor & HOD, Geriatrics

Dr. Shailaja Rao
Associate professor, Geriatrics

FREE PAPERS

"GERIATRIC CARE OF EDENTULOUS PATIENTS THROUGH DENTAL IMPLANTOLOGY"

ABSTRACT

Advancements in the medical technology have led to the increase in the life expectancy of the general population. This rise is expected to be maintained in recent future. Hence the proportion of the geriatric patients is on rise. It is reflected in the increased number of the edentulous patients. The oral environment of the geriatric edentulous persons is unique in view of aging. The geriatric patients present with specialized oral health care needs for this specific group of population. A shift from the dentulous state to complete edentulism is a transition that is burdened with concern by the patient. Traditionally, conventional mucosa borne complete dentures have been considered a standard of care for rehabilitation. Edentulous patients having severely resorbed mandible often experiences problems with their complete removable dentures, such as limited denture stability and retention leading to reduced masticatory efficiency and dissatisfaction. The dental implantology has emerged as an established alternative to increase the stability of the prosthesis and improve the masticatory efficiency. Implant retained overdentures offers many advantages over conventional dentures, such as reduced rate of bone resorption, reduced or eliminated prosthesis movements, better esthetics, increased occlusal function and maintenance of the occlusal vertical dimension, improve phonetics, the patient's psychological outlook and quality of life. The oral rehabilitation of geriatric edentulous patients with implant retained complete denture assists improved outcome.

Dr. Manu Rathee
MDS, DNB
MNAMS, FPFA, FICD, FICCDE
Senior Professor & Head
PGIDS, Health University, Rohtak, Haryana

FREE PAPERS

PROFILE OF CLINICAL AND PULMONARY FUNCTIONS OF GERIATRIC PATIENTS WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE EXPERIENCING FREQUENT ACUTE EXACERBATIONS

ABSTRACT

Objectives: This study aims of clinical and pulmonary functions profiling of geriatric COPD patients with frequent exacerbations, to know the future course.

Study Design: Cross sectional study.

Setting: Hospital based respiratory clinic of Geriatrics, Department at a tertiary care center.

Methods: The study includes 70 geriatric COPD patients, All had more than 2 exacerbations in previous 2 years. Clinical profile. BMI, risk factors and Spirometric indices were assessed in detail. Similarly the details of treatment and adherence to treatment also assessed by questionnaire.

Results: Main risk factors was 23 pack year of smoking. It was followed by occupational hazards in farmers growing predominantly sugarcane and cotton (20%), smokeless tobacco uses (10%), other risk factors included biomass fuel exposure while cooking on chulhas, mill worker etc.

Conclusion: Patients experiencing frequent exposure had long pack years and lower FEV1, on pulmonary functions test, >85%, patients did not know how to use the inhalers correctly. Respiratory clinics dedicated to geriatric population is the need of the hour.

Dr. Anand Wakure
Fellowship Course in Geriatrics

Dr. Mangala Borkar
Dr. Professor and Head

Dr. Shailaja Rao
Associate Professor
Department of Geriatrics
GMC Aurangabad, Maharashtra, India

News from Vijayapura

Dr. Anand P. Ambali

Sensitization program on inter generational bonding & Maintenance and Welfare of Parents & Senior Citizen Act 2007.

The Geriatric Clinic in collaboration with the Nightingales Medical Trust Bengaluru had organised sensitization program on Intergenerational Bonding & Maintenance and Welfare of Parents & Senior Citizen Act 2007 on 16/03/2019 between 03.00PM to 05.00PM in Lecture Hall No one at BLDE (DU) Shri B M Patil Medical College hospital premises. This program was sponsored by National Institute of Social Defence, Ministry of Social Justice and Empowerment, Government of India .

A total of 200 students participated in the program which was well taken.

The information shared by Dr. Santoshkumar B. Potadar regarding Intergenerational Bonding and Mr. Praveen Kumar Anthony regarding Maintenance and Welfare of Parents & Senior Citizen Act 2007 were very useful especially for the young students and awareness about the care of their parents was emphasized which was taken positively by the students.

Overall the students were enthusiastic in both the sessions as it was first of its kind held in recent times. The principal Dr. S. P. Guggarigoudar along with faculties and students inaugurated the program. Dr. Anand P. Ambali , Dean student Affairs was the coordinator of the program. Dr. Sonam mastered the ceremony, Dr. Anusha read the report of Geriatric Clinic so far and Dr. Pranav proposed vote of thanks.

News from Ernakulam

Dr. Arun N Bhatt

A one day program named 'Anukalikam' (meaning - current affairs) was organized by Department of Community Medicine, Malankara Orthodox Syrian Church Medical College, Kolenchery (Eranakaulam, Kerala) on 28th November 2018. The program was funded by ReAct Asia Pacific (Action on Antibiotic Resistance) and was conducted in association with Kerala Chapter of Geriatric Society of India (GSI). In the forenoon, symposium was presented on topic 'Antibiotic Resistance and Environment' and in the afternoon, on topic 'Fall prevention in old age'. A total of 127 participants attended who were elected members of 6 panchayaths, ASHA, JPHN and JHI of 7 Primary Health Centres in the area of Vadavucode Block Panchayath.

The Program was inaugurated by the Vadavucode block panchayath president, Smt. Gowry Velayudhan. Presidential address was delivered by Sri. Joy P. Jacob (Secretary, MOSC Medical College) and key note address was delivered by Dr. K.K. Diwakar (Dean, MOSC Medical College). Dr. Sojan Ipe (Medical Superintendent, MOSC Medical College), Dr. Philip Mathew (Consultant, ReAct) and Dr. Sajesh Asokan (Secretary, Kerala Chapter, GSI) felicitated. The program was benedicted by Rev. Fr. John Kuiakose (Department of Chaplaincy, MOSC Medical College). Welcome speech was delivered by Dr. Accamma PK (Head of the Department, Community Medicine) and vote of thanks was delivered by Dr. Sumit Datta (Department of Community Medicine).

News from Kolkata

Dr. Kaushik Ranjan Das

Geriatric Society Of India West Bengal branch has organised seasons CME programme in association with Zenith Super speciality Hospital Kolkata on 03.01.2019 at 1.30 pm. There have been two CME sessions. Ist speaker was Dr. Arup Bhattacharya NRI from Australia, who talked on recent advances in Parkinsons Disease, Chair Person - Dr. Kaushik Ranjan Das. 2nd speaker was Dr. Ashoke Kumar Das, talked on Overview of imaging with its relevance in geriatric diseases; Chairpersons were Dr. Ratna Sanyal & Dr. Chinmay Kumar Maity. Being attended by about 40 delegates & with felicitation of elderly parents of Dr. Arup Bhattacharya, the programme has been a successful activity.

Congratulation for forming Eastern Zonal Branch of Geriatric Society of India on 29th March 2019.
The following office bearers were elected: -
Patrons
(1) Dr. Amsuna Singh
(2) Prof.Dr. Subhas Chandra Mahapatra
(3) Prof.Dr. Hari Shankar Pathak
Advisors :
(1) Dr.(col.) Promod Kumar
(2) Dr. Aloke Dasgupta
(3) Dr. Surendra Daga
(4) Prof. Dr. Jyotirmoy Pal
Chairman Prof. Dr. Arunansu Talukdar
Vice Chairmen :
(1) Prof. Dr. Sanjeeb Kakoty
(2)Prof.(Retd.)Dr. Ashoke Das
(3) Dr. Mrs. Taruni Ngangbam
(4)Dr. Ashok Kumar Parida
General secretary : Dr. Kaushik Ranjan Das
Joint Secretary :
(1) Dr. Pranjal Kumar Dutta
(2) Dr. Prasanna Kumar Rathor
Assistant secretary : Dr. Rakesh Kumar Jha
Treasurer: Dr. Aniruddha De
Assistant Treasurer : Birja Prasad Biswal
Committee Members :
(1) Dr. Thoidingiam Bijoy Singh
(2) Dr. Mrs. Papori Salkia
(3) Dr. Sriti Sinha
(4) Dr. Anirban Mohanta
(5) Dr. Sudhir Kumar Gupta
(6) Dr. Ajit Narayan Deb
(7) Dr. Amulya Kumar Das
(8) Dr. Sudhir Ranjan Samal
(9) Dr. Soumik Ghosh

CME

Collaborative Symposium with Indian Menopause Society

GSI West Bengal chapter has conducted a Symposium on Geriatric Giants (frailty & Sarcopenia, Dysmobility- joint problems and Dementia) related to Post menopausal women at Hotel ITC Sonar, Kolkata at IMSCON on 17.02.2019.. Speakers has been Dr. Chinmay Kumar Maity, Dr. Suddhasatwya Chatterjee & Dr. Kausik Majumdar respectively. I have coordinated the programme. Great achievement of Team GSI West Bengal.

News from Kolhapur

Dr. Mahaveer Mithari

GSI Kolhapur chapter in association of Kolhapur Medical Association, branch of IMA & Aster Aadhar hospital had arranged CME on ' Geriatric Health'.

Dr. Amol Kulkarni (Gastroenterologist), Dr. Pravin Ghule (Nephrologist), Dr. Amol Kodolikar (Intensivist), Dr. Anand Ambali (Geriatric Physician, Vijaypura) were guest faculties, they had expressed thoughts regarding their subjects in Geriatric health. Near about 70 doctors attended the function. Everybody enjoyed pannel discussion regarding geriatric health.

News from Miraj – Sangali

Dr. Anita Basavaraj

The Geriatric Society of India Miraj Sangali Chapter was installed on 5th December 2018 after due permission and blessings of Dr O.P. Sharma and Dr P.S. Shankar.

The installation was done in the Campus (Pharmacology lecture hall) of Government Medical College Miraj. The GSI Dignitaries were Dr. Ramnathan Iyer, Dr Anand Ambali, Bijapur & Dr Sandeep Tamane.

The following were installed

1.Dr Anita Basavaraj - Chairperson
2.Dr Sunil Patil= Vice Chairman
3.Dr Wilson Desai- Vice Chairman
4.Dr Mrs P.B.Palange- Secretary
5.Dr sachin Patankar - Joint Secretary
6.Dr Madhura Killedar- Joint Secretary
7.Dr Padmakar Shingade- Treasurer

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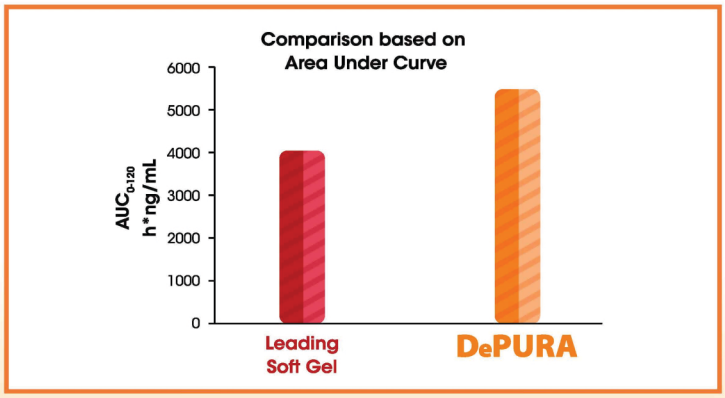

References:

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