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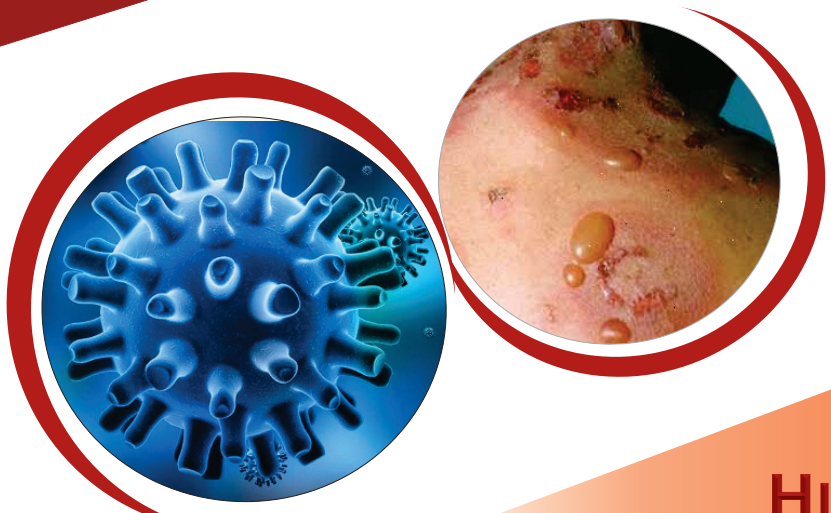

HIGHLIGHTS

Stroke in Elderly

Atypical Presentation of Herpes Zoster in an Elderly Male

Bullous Pemphigoid in A Elderly Female with Diabetes: A Case Report

With Best Compliments From

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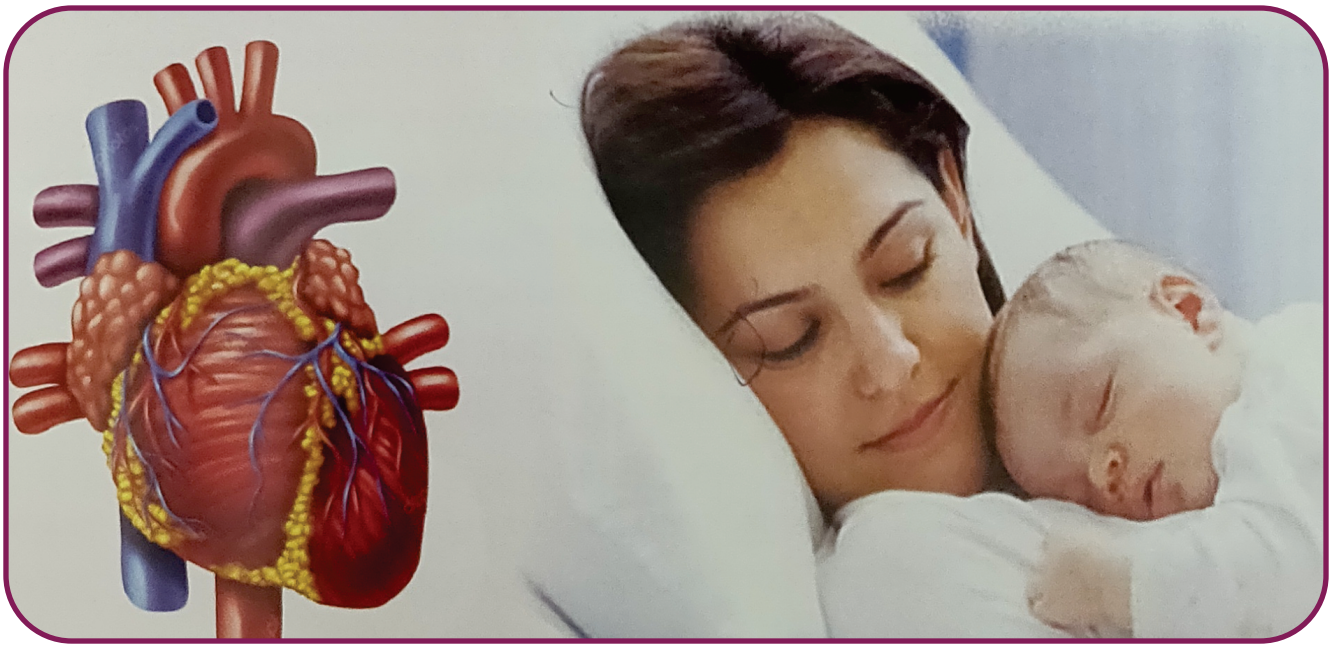

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Role of Auxiliary Nurse-Midwife (ANM) & Accredited Social Health Activist (ASHA) Workers in Geriatric Care

There is no doubt to state that the ANM & ASHA workers are the backbone of the health care system in India. There are at present 208,000 ANMs and 857,000 ASHA workers. The only means by which the heath care is reaching to the rural mass is through the ANM & ASHA workers irrespective of seasons.

In all the health programs launched by Central or State government, which may be either diagnostic, screening or preventive, these workers have been playing vital role in its effective implementation. They are paid incentives for all the programs. They are now equipped with tabs with internet connection through which they have to upload day to day activities & data online.

I have been training ANM & ASHA workers in Geriatric Care through Geriatric Clinic of BLDE DU, TATA Trust, Yadgir & Vijayapura District Health Administration in Karnataka for National Program of Health Care for Elderly (NPHCE). I have observed that they were very curious in learning geriatric care.

I conduct workshop on Comprehensive Geriatric Assessment and sensitize them regarding approach and common health problems in older people. At the end of training session, in their feedback, they openly said that even though they don't receive incentive for this program, we shall definitely continue to work & will try to reach all the health schemes for the older people of their respective villages. Such a positive attitude & commitment of these ANM & ASHA workers is worth to be emphasized & deserves to be notified all over India. We need to incorporate them in geriatric care from now itself so that the upcoming programs with emphasis on screening & prevention of the diseases in older people can be implemented effectively all over the country.

REVIEW ARTICLE

Stroke in Elderly

BINDU MENON*

Abstract

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Keywords: .....

INTRODUCTION

Stroke is one of the leading causes of death and disability and it is more likely to occur in those who are older. Age should not be a barrier for the patient to receive effective treatment.

Over the next century we will be witnessing an increase in the number of stroke patients as the aging population is fast increasing.[1] Aging comes with its unique health issues. These are chronic health conditions, cognitive decline, changes in mental health, increased tendency to falls, malnutrition, sensory impairments, altered oral health, bladder and bowel habits. The co morbidities in the elderly patient with stroke can make the treatment more challenging. Co morbid diseases like osteoarthritis make mobilization difficult.[2] Age is one of the non-modifiable risk factors for stroke. Apart from the health and nutritional issues the aging population also faces other challenges like risk of abuse, neglect, separation from family and being cut from the service.

Another hurdle is that the very old are often excluded from clinical trials, and therefore there is little evidence of whether treatments are as effective as they are for those under 80 years of age.[3,4]

The management of stroke is by prevention, hyperacute stroke treatment, acute stroke care and rehabilitation.

PREVENTION

Primary prevention aims at treating hypertension, diabetes, anticoagulation for atrial fibrillation (AF), statins, lifestyle modification and influenza vaccination.

Secondary prevention treatment for AF, antiplatelet therapy, statins, blood pressure, DM, lifestyle, influenza vaccination and carotid endarterectomy.

HYVET trial (Hypertension in the Very Elderly), have provided data on the benefits and risks for those over 80 years of age.[5] The SPRINT study (Systolic Blood Pressure Intervention Trial) has provided additional support for a strategy of blood pressure lowering, with over a quarter of participants aged 75 years or older.[6]

With age the cardioembolic stroke due AF increases. The BAFTA trial (Birmingham Atrial Fibrillation Treatment of

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the Aged) recruited older people (aged ≥75 years) with AF, who were eligible for anticoagulation, demonstrating that warfarin anticoagulation (international normalized ratio target, 2–3) was superior to aspirin 75 mg daily, with a 2% absolute annual reduction in stroke and arterial embolism.[7]

There is accumulating evidence that influenza itself could be a trigger of major CVD.[8] Influenza is common and elderly are at higher risk of the complications from the illness. Influenza vaccination can be offered to all the very elderly.

Life style changes include stopping smoking; avoiding obesity, eating a healthy diet, and remaining physically active. Lowering blood cholesterol (other than diet), in the primary prevention setting, is controversial.

Secondary prevention focuses on stopping smoking, blood pressure reduction, antiplatelets, antithrombotic therapy, statins and carotid intervention.

HYPERACUTE STROKE TREATMENT

A hyper acute stroke treatment is aimed at preventing brain damage by reversing the cause of the stroke. It is a time bound treatment. Thrombolytic therapy and thrombectomy has revolutionized stroke treatment by prevention stroke progression and also reversing the stroke symptoms in a large number of cases. Elderly patients also should be admitted in the dedicated multidisciplinary stroke units.

Studies have shown that organized stroke care led to a 20% reduction in both mortality alone (odds ratio (OR) 0.81) and the combined outcome of death and disability (OR 0.79).[9]

This holds true for the elderly stroke as well because of the risk of having institutional care is high among them. Stroke units also helps to prevent further complications which will decrease the hospital stay.

Intravenous thrombolysis has become an important part of hyperacute stroke treatment. Third International Stroke Trial (IST-3)—the largest study of thrombolysis in acute stroke to date included patients over the age of 80. Fifty-three percent of the 3035 patients enrolled in the study were over the age of 80. Though there was an early increase in mortality due to intracerebral haemorrhage, overall mortality at 6 and 18 months was not affected by thrombolysis

The study showed that the best outcomes were in patients who were treated in less than three hours from the symptom onset. The studies have not included patients who were bed ridden before the stroke. However in the very old and very frail the decision to thrombolyse should be individualized.

Mechanical thrombectomy (MT) has become the standard treatment for large vessel occlusion (LVO) in acute ischemic stroke (AIS). The elderly patients may have at least as much to gain from this procedure as younger people, and that age alone should not be a factor when making the decision to offer thrombectomy to such patients. Th stroke specialist should keep all variables and factors while treating patients.

ACUTE STROKE CARE

Dysphagia is a common complication of stroke seen in around 50% of acute stroke. Dysphagia screening reduces the risk of pneumonia by 60% and has a major impact on outcomes and long-term prognosis. Another serious complication in acute stroke is deep vein thrombosis (DVT). Prophylactic anticoagulation with heparin (unfractionated or low molecular weight) is effective at preventing DVT, but also increases the risk of both intracranial and extracranial haemorrhage.

Full therapeutic anticoagulation is recommended for patients with diagnosed DVT and pulmonary embolism. In patients with an intracerebral haemorrhage, a vena cava filter might be an alternative, but with anticoagulation in the longer term.

Care should be taken to prevent decubitus ulcers. Immobility, malnutrition, dehyDr. ation, urinary and faecal incontinence all increase the risk of pressure ulcers. Regular skin assessment, air mattresses and barrier cream can prevent ulcers to a large extent. Incontinence is very high in the acute stage leading to high rates of morbidity, longer hospital stay. It will also lead to institutional care. This leads to a higher risk of developing urinary tract infection. Behavioral interventions, pharmaceutical treatments and long-term catheter as potential options.

Falls are very common among elderly restricting proper rehabilitation. Apart from fractures and functional limitations, the fear of fall also restricts rehabilitation. It is wise to install hanDr. ails; non-slip mats, improving the lighting, install grab bars and repair steps and flooring.

There have been great changes in stroke treatment over time and the same evidence based medicine should be applied to stroke care in elderly. Stroke tends to be more severe in above the age of 80.

More embolic strokes due to atrial fibrillation and larger infarcts (more M1 occlusion) are noticed.

A transitional care approach from the acute stroke care to more personalised care for stroke in elderly needs to be in place.

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Idiopathic Pulmonary Fibrosis (IPF)

AUTHOR

Abstract

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Keywords: .....

INTRODUCTION[1,2]

Interstitial lung diseases, also known as diffuse parenchymal lung diseases (DPLD) are a group of disorders involving the distal lung parenchyma. In 1944, Hamman and Rich in 1944 described several cases of "diffuse interstitial fibrosis of the lungs" which were rapidly progressive and fatal within a few weeks or months. These cases were thought to be the chronic stage of Hamman–Rich syndrome and were termed as "idiopathic pulmonary fibrosis". Subsequent studies had shown that Hamman–Rich syndrome had no chronic stage and the condition similar to this is now termed as acute interstitial pneumonia (AIP). There are more than 200 diseases with lung interstitial involvement with similar clinical, physiologic and radiographic manifestations.

The interstitial lung diseases (ILD) are characterized by cellular proliferation, interstitial inflammation, fibrosis, or a combination of such findings within the alveolar wall due to causes other than infection or cancer. Interstitial fibrosis is the commonest phenotype in most cases. The majority of patients with interstitial fibrosis may be diagnosed as chronic hypersensitivity pneumonitis (due to mold or bird exposure), pulmonary sarcoidosis, an underlying autoimmune disease, or, an idiopathic interstitial pneumonia in case no cause is identified.

Idiopathic pulmonary fibrosis (IPF) is the most common idiopathic interstitial pneumonia, is a chronic, progressive, fibrotic interstitial lung disease of unknown cause, often with characteristic imaging and histologic appearances (described below), that occurs primarily in adults belonging to older age groups. IPF is of particular clinical interest because it is often misdiagnosed and managed inappropriately with immunosuppressive therapy and it is associated with a high mortality rate.

Interstitial lung disease (ILD) classification[1]

With the passage of time many classifications of ILD has come up:

Previous classifications of idiopathic interstitial pneumonia (IIP)

I. Classification by Leibow and Carrington

i. Usual interstitial pneumonia
ii. Desquamative interstitial pneumonia
iii. Bronchiolitis obliterans interstitial pneumonia
iv. Lymphoid interstitial pneumonia
v. Giant cell interstitial pneumonia

II. Classification by Katzentein

i. Usual interstitial pneumonia
ii. Desquamative interstitial pneumonia/respiratory bronchiolitis interstitial lung disease.
iii. Acute interstitial pneumonia
iv. Non-specific interstitial pneumonia

III. Classification by Muller and Colby

i. Usual interstitial pneumonia
ii. Desquamative interstitial pneumonia
iii. Bronchiolitis obliterans organizing pneumonia
iv. Acute interstitial pneumonia

*

Table 1: New Classification of Idiopathic Interstitial Pneumonias

Histologic pattern	Clinical-Radiologic-Pathologic diagnosis
Usual interstitial pneumonia	Idopathic pulumonary fibrosis/ cryptogenic fibrosing alveolitis
Non-specific interstitial pneumonia	Non-specific interstitial pneumonia (Provisional)
Organizing pneumonia	Cryptogenic organizing pneumonia
Diffuse alveolar damage	Acute interstitial pneumonia
Respiratory bronchiolitis	Respiratory bronchiolitis interstitial lung disease
Desquamative interstitial pneumonia	Desquamative interstitial pneumonia
Lymphoid interstitial pneumonia	Lymphoid interstitial pneumonia

Adapted from ATS/ERS International Multidisciplinary Consensus Classification of the Idiopathic Interstitial Pneumonia. Am J Respir Crit Care Med 2002; 165:277-304

v. Non-Specific interstitial pneumonia

A small subset of patients with interstitial pneumonia remains unclassified even after extensive clinical radiological and/or pathologic evaluation. (Table 1)

EPIDEMIOLOGY[2]

IPF is globally prevalent. The prevalence of the disease appears to be increasing, although it is unclear whether this reflects increased recognition or a true increase in incidence. The incidence of IPF appears to be higher in North America and Europe (3 to 9 cases per 100,000 person-years) than in South America and East Asia (fewer than 4 cases per 100,000 person-years).In the United States, the prevalence of IPF has been reported to range from 10 to 60 cases per 100,000, although in one study, the prevalence was 494 cases per 100,000 in 2011 among adults over the age of 65 years, which was twice as high as the prevalence recorded 10 years earlier. an increasing burden of disease maybe indicated by increasing rates of hospital admissions and deaths due to IPF.

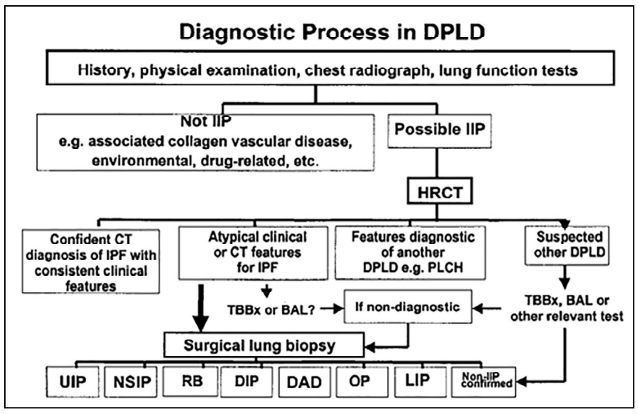
Despite being well recognized in the West, the entity has still not received due attention in India, and is often clubbed under the broad category of ILD. The exact Indian population prevalence of the disease is not known. The most important risk factors for IPF include old age, male gender, cigarette smoking, and gastroesophageal reflux, of which smoking is the most important modifiable factor. The prevalence of smoking in India is 10-16% and smoking related diseases such as chronic obstructive pulmonary disease (COPD) and lung cancer are prevalent in this country. Therefore, IPF should be as prevalent as in other regions of the world. Four studies from tertiary care centers in India reported that among patients with diffuse parenchymal lung diseases, 29-48% patients had IPF.

CLINICAL PRESENTATION[2]

ILD should be considered as a differential diagnosis for adults presenting with unexplained exertional dyspnea, chronic dry cough, or Velcro like crackles on examination. Exertional dyspnea typically progresses over a period of months to years. In practice, patients with interstitial lung disease often initially misdiagnosed as heart failure or COPD. High degree of suspicion is necessary to reach appropriate and timely diagnosis. In some cases, patients have presented with dyspnea and dry cough up to 5 years before interstitial lung disease was diagnosed. Early and precise diagnosis may show likely improvement in clinical outcomes through avoidance of potentially harmful therapies (e.g., glucocorticoids for IPF) and prompt initiation of therapies in the early stages of disease.

DIAGNOSIS[3]

The process of achieving a diagnosis in a patient with IIP is dynamic, requires multidisciplinary discussion between clinician, radiologist, and pathologist. The approach to patients with DPLD begins with a careful history followed by physical examination, routine chest radiographs, and pulmonary function testing. The assessment of the clinical history should include the nature of the first symptoms (usually breathlessness or cough), their progression, clinical course, and in particular the presence of comorbid disease such as collagen vascular disease or immunodeficiency disorders such as infection with the human immunodeficiency virus (HIV). A record of environmental exposures including smoking status, drug use, and detailed occupational exposures with dates, duration of exposure is essential.



RADIOLOGICAL EVALUATION[3]

High-resolution computed tomography (HRCT) has become an integral part of the evaluation of the patient with IIP. It is indicated for all but a small proportion of patients for whom a specific diagnosis is strongly suggested by the standard chest radiograph. Careful attention to technique is necessary to assure diagnostic accuracy. HRCT images should be performed in accordance with established guidelines and interpreted by a radiologist experienced in the evaluation of diffuse lung diseases. When interpreting the HRCT scan of a patient with diffuse lung disease, the radiologist must first determine the presence or absence of a pattern typical of usual interstitial pneumonia (UIP). In more than 50% of cases suspected to be IPF/UIP, the presence of typical clinical and HRCT features of UIP, when identified by expert clinicians and radiologists, is sufficiently characteristic to allow a confident diagnosis. Surgical lung biopsy may not be needed in such patients. The HRCT may also provide clues to non-IIP disorders such as sarcoidosis, hypersensitivity pneumonitis, lymph angioleiomyomatosis, Langerhans' cell histiocytosis, and pulmonary alveolar proteinosis, and may prompt the selection of bronchoscopy (usually with both bronchoalveolar lavage and transbronchial biopsy) in preference to proceeding to a surgical lung biopsy. Therefore, the primary role of HRCT is to separate patients with UIP from those with non-UIP lesions or those with less specific findings associated with other idiopathic interstitial pneumonias (NSIP, RB-ILD, DIP, and AIP) (Table 2).

ROLE OF BRONCHOSCOPY:[4]

Until recently, surgical lung biopsy (SLB) has been regarded as the golden standard in the diagnosis of IPF and other types of IIP. During the past decades, the pathological and clinical terms for the IIPs have been at least partly different which has been responsible for misinterpretations between different specialists working with the patients with IIP. The international statement on the diagnosis and management of IPF has recommended adopting a multidisciplinary approach for the ultimate diagnosis. On the other hand, in case of clinically and radiological typical usual interstitial pneumonia

Table 2: Radiologic features and differential diagnosis of idiopathic interstitial pneumonias

Clinical Diagnosis	Histologic Pattern	Usual Radiographic Features	Typical Distribution on CT	Typical Findings	CT Differentials Diagnosis
IPF/CFA	UIP	Basal-predominant reticular abnormality with volume loss	Peripheral, subpleural, basal	Reticular, honeycombing Traction bronchiectasis/ bronchiolectasis, architectural	Asbestosis Collagen vascular disease Hypersensivity pneumonitis Sarcoidosis
NSIP, Provisional	NSIP	Ground glass and reticular opacity	Periphara, subpleural, basal symmetric	Ground glass attenuation Irregular lines Consolidation	UIP, DIP, COP Hypersensitivity pneumonitis
COP	OP	Patchy bilateral consolidation	Subpleural/ peribronchial	Patchy consolidation and/or Nodules	Infection, vasculitis, sarcoidosis, alveolar carcinoma, lymphoma, eosinophific pneumonia, NSIP
AIP	DAD	Progressive diffuse ground Glass density/consolidation	Diffuse	Consolidation and ground glass opacity, often with Lobular sparing Traction bronchiectasis later	Hydrostatic edema Pneumonia Acute eosinophilic pneumonia
DIP	DEIP	Ground glass opacity	Lower zone, Peripheral predominance In most	Ground glass attenuation Reticular lines	RB-ILD Hypersensitivity pneumonitis Sarcoidosis, PCP
RB-ILD	RB	Bronchial wall thickening; ground glass opacity	Diffuse	Bronchial wall thickening Centrilobular nodules Patchy ground glass opacity	DIP NSIP Hypersensitivity pneumonitis
LIP	JIP	Reticular opacities, nodules	Diffuse	Centrilobular nodules, ground glass attenuation, Septal and bronchovascular thickening, thin-walled cysts	Sarcoidosis, lymphangitic carcinoma, Langerhans'cell histiocytosis

Definition of abbreviation: *AIP: acute Interstitial pneumonia; CFA: cryptogenic fibrasing alvelitis; COP: cryptogenic OP; DAD: diffuse alveolar damage; DIP: desquamative interstitial pneumonia; IPF: idiopathic pulmonary fibrosis; LIP: lymphoid interstitial pneumonia; NSIP: nonspecific interstitial pneumonia; OP: organizing pneumonia; PCP: Pneumocystis carnill pneumonia; RB-ILD: respiratory bronchiolitis-associated Interstitial lung disease; UIP: usual interstitial pneumonia*

Table 3: Role of Bronchoscopy

UIP pattern (All four criteria)	Probable UIP pattern	Possible UIP pattern (All three criteria)	Not UIP pattern
Marked fibrosis/architectural distortion,± Honeycombing in a predominantly Subpleural/ paraseptal distribution	Marked fibrosis/architectural distortion, ± honeycombing	Patch or diffuse involvement of lung parenchyma by fibrosis, with or without interstitial inflammation	Hyaline membranes Organizing pneumonia Granulomas Marked interstitial inflammatory cell infiltrate distant from hyneycombing
Presence of patchy involvement of Lung parenchyma by fibrosis	Absence of either patchy involvement or fibroblast Foci, but not both	Absence of other criteria for UIP (see UIP pattern column)	
Presence of fibroblast foci	Absence of features Against a diagnosis of UIP suggesting an alternate Diagnosis (see fourth column)	Absence of features against a diagnosis of UIP suggesting an alternate diagnosis (see fourth column)	Predominant airway centered changes
Absence of features against a Diagnosis of UIP suggesting an Alternate diagnosis (see fourth column)	OR Honeycomb changes only		Other features suggestive of an alternate diagnosis

Abbreviations: IPF: idiopathic pulmonary fibrosis; UIP: usual interstitial pneumonia

(UIP) with no known causes, the diagnosis can be made without bronchoscopy, transbronchial biopsy (TBB), bronchoalveolar lavage (BAL) or SLB procedures. Traditionally, SLB has been performed as a basic diagnostic tool for investigating a patient with suspected IPF, whereas nowadays needed for the ultimate diagnosis of the non-typical IPF patients who do not fulfill the precise criteria for UIP in HRCT. These atypical IPF patients may have other diseases, which along with some confounding factors can complicate the diagnosis. Several studies have shown that SLB taken by either open lung thoracotomy (OLB) or video-assisted thoracoscopic surgical (VATS) operation is an efficient diagnostic procedure for ILD. Mouroux et al. compared the efficacy and safety of VATS and OLB in the diagnosis of ILD and revealed that in conjunction with compatible efficacy and similar morbidity and mortality, VATS offered several advantages such as reduction of the time of surgery as well as hospitalisation. As per the recent statement of IPF individual patient characteristics, clinical situations and surgical expertise should be taken into consideration before taking decision to perform SLB (Table 3).

DISEASE PROGRESSION AND LIFE EXPECTANCY:[5]

The rate of decline and disease progression in patients with IPF may take several clinical forms such as slow physiologic deterioration with worsening severity of dyspnea, rapid deterioration and progression to death, or periods of relative stability interposed with periods of acute respiratory decline sometimes manifested by hospitalizations for respiratory failure.

a) Subclinical IPF

It is well recognized that symptoms precede diagnosis by a median of 1 to 2 years, and sometimes radiological findings of disease may even precede symptoms, suggesting ''subclinical'' periods of disease that may not be characteristic. This progression of asymptomatic to symptomatic IPF may occur over years to decades.

b) Slowly Progressive IPF

The classic clinical phenotype of IPF is one of slowly progressive decline in lung function and worsening dyspnea leading to death within several years of diagnosis. The mean annual rate of decline in progressive disease, as measured by the FVC, ranges from 0.13 L to 0.21 L. It appears that this slowly progressive clinical course may actually be less common than it was assumed to be previously.

c) Rapidly Progressive IPF

Selman and coworkers identified a subgroup of patients with IPF who displayed a rapidly progressive disease (6 months of symptoms before first presentation) and showed shortened survival compared with patients following the slowly progressive clinical course. These were primarily men who were chronic cigarette smokers.

d) Acute Exacerbations of IPF

Patients with IPF may suffer periods of acute respiratory decline either due to known complications, such as infection, or of unknown cause (i.e., acute exacerbation of IPF). Acute exacerbation of IPF is defined by the onset of rapid deterioration (within days to a few weeks) in symptoms, lung function, and radiographic appearance (bilateral ground-glass opacities and consolidation superimposed on a reticular

Table 4: Pharmacologic Management of IPF*

Variable	Nintedanib	Pirfenidone
Mechanism of action	Tyrosine kinase inhibition	Inhibition of TGF-b production and downstream signaling, collagen synthesis, and fibroblast proliferation (selected list)
Efficacy	Slows FVC decline by 50%	Slows FVC decline by 50%
FDA-approved dose	150 mg by mouth twice daily	801 FVC decline by 50%
Common side effects	Diarrhoea	Anorexia, nausea, photosensitivity
Enzyme metabolism	Ester cleavage (major), CYP 3A4 (minor)	CYP 1A2 (major), other CYP enzymes (minor)
Cautions	Risks of both bleeding and arterial thrombosis Risk of gastrointestinal perforation (rare); anticoagulant and prothrombotic Drugs should be avoided	CYP 1A2 inhibitors (e.g., fluvoxamine and ciprofloxacin) can raise pirfenidone levels; CYP 1A2 inducers (e.g., omeprazole and smoking) can lower pirfenidone levels
Need for liver-function monitoring	YES	Yes
Clinical strategies to minimize side effects	Use of antidiarrheal agents, temporary dose reduction to 100 mg twice daily	Slow dose increase over 14-day period, medication to be taken with food, use of antacids, use of antiemetic agents, Sun avoidance

Adapted from DJ. Lederer et al. Idiopathic Pulmonary Fibrosis. N Engl J Med 2018;378:1811-23.

pattern on HRCT) in the absence of infection, heart failure, pulmonary embolism, or other identifiable cause. Patients with acute exacerbations of IPF have a very poor outcome.

THERAPEUTIC OPTIONS[4]

Various novel therapeutic options have now come up in the management of IPF patients. In clinical trials of some drugs like etanercept, IFNγ, bosentan, imatinib mesilate in patients with IPF who have mild-to-moderate functional impairment, no significant benefit was reported. For several new therapies, there is evidence to suggest clinical benefit in patients with IPF. N-Acetylcysteine, an antioxidant, used in combination with prednisone and azathioprine, reduces the rate of decline in FVC and DLCO after 12 months of treatment. However, the observed changes are of uncertain clinical significance. Pirfenidone, a novel compound that inhibits TGFβ in vitro, decreased the rate of decline in vital capacity and increased the progression free survival time over 52 weeks. Pirfenidone has a number of anti-inflammatory and antifibrotic effects, including inhibition of collagen synthesis, down-regulation of TGF-β and tumor necrosis factor alpha, and a reduction in fibroblast proliferation. Nintedanib is a tyrosine kinase inhibitor that targets growth factor pathways, including those downstream from vascular endothelial growth factor receptors 1, 2, and 3, fibroblast growth factor receptors 1, 2, and 3, and platelet-derived growth factor receptor (Table 4).

As there have been no head-to-head comparisons, It is difficult to recommend one agent over the other. A network meta-analysis concluded that pirfenidone and nintedanib showed similar benefits. No data are available to guide clinicians regarding the timing of initiation of therapy, how a response should be defined, and when the therapy should be discontinued. Recent studies on the combination these agents suggest clinically significant gastrointestinal side effects.

CONCLUSION

In light of the rising prevalence of IPF and the increase in associated mortality, greater recognition of the disease on the part of primary care providers, leading to earlier involvement of a multidisciplinary team to aid in diagnosis and management is a need of an hour. Novel interventions to prevent the disease, evolving use of screening biomarkers, and the eventual ability to target newly discovered risk factors for IPF could lead to a decline in the incidence of this disease as well as other fibrotic interstitial lung diseases in coming years. Advances in therapeutics, including individualized approaches and interventions to stop collagen deposition, may one day eliminate the need for lung transplantation and turn IPF into a lifelong chronic disease. Thus, the fundamental challenge for the future is to find appropriate therapeutic approaches that will reverse or stop the progression of the disease.

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Atypical Presentation of Herpes Zoster in an Elderly Male

KAUSHIK RANJAN DAS*

Abstract

Herpes Zoster or Shingles is characterized typically by a painful skin rash with blisters in a localized area due to reactivation of Varicella Zoster Virus that remains dormant in dorsal nerve root ganglion after initial infection (chicken pox).[1] Atypical prsentation of the disease is seen in immunocompromised patients but here atypical presentation (only nodolar rash)occurred in otherwise healthy elderly male that responded to treatment with oral and topical acyclovir & resulted in recovery.

Keywords: *Shingles, atypical presentation, nodular rash, chicken pox, acyclovir.*

PRESENTATION

A 62 years male presented with history of numbness over left axilla with slight pain over left scapular region for 2(two) days ,following which he developed small nodular swellings over left upper chest followed by similar swellings over left upper back near back bone. He was non diabetic with history of chickenpox during childhood. He was on olmesartan & metoprolol for hypertension for long time.

On examination

Vitals were normal, small reddish nodular erruption was seen over left 2nd intercostal space near sternal margin & multiple small nodular erruptions over upper third of medial margin of left scapula; corresponding to T2 dermatomal segment. (Figure 1-4)

Provisional diagnosis

With past history of chicken pox , numbness over the region & skin rash (unilateral) with same dermatomal segmental distribution ; clinically it is a case of Herpes Zoster.

Differential diagnosis

Insect sting , contact dermatitis,impetigo ,furuncles etc.[2]

*General Secretary, Geriatric Society of India Eastern Zonal branch.

DISCUSSION

Since presentation is unilateral & lesions located along a definite dermatomal segmental distribution & since no other part of the body is involved and there is no pus formation and no history of insect sting or contact to a offender—contact dermatitis, impetigo & furuncles have been ruled out. Although PCR & direct fluorescent antibody test from swab/ scrapping from lesion have been used for diagnosing doubtful cases; in the present case there were no vesicles /

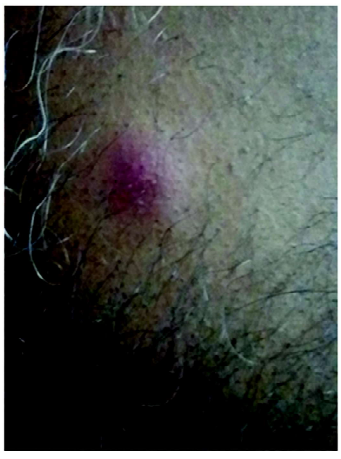


Figure 1: Rash at the outset : Number -1, rash near left sternal border

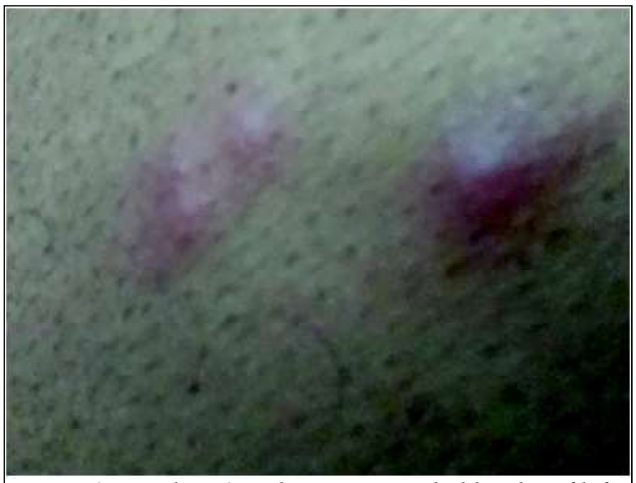


Figure 2: Number -2 rash at upper medial border of left scapula

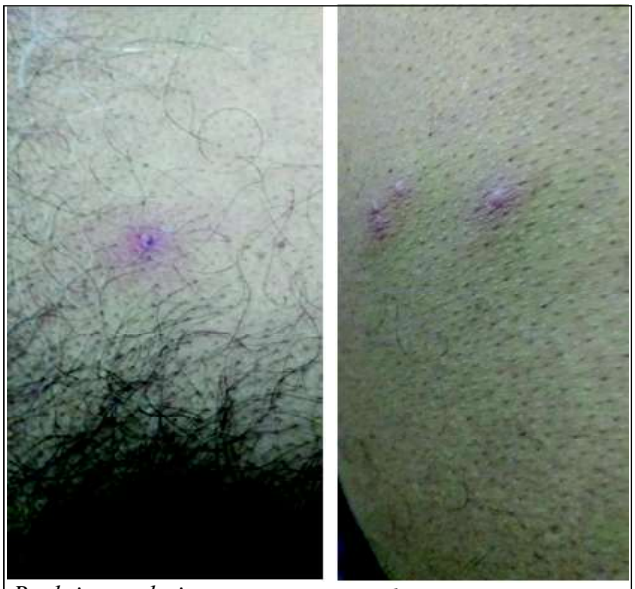
blebs. Since IgM & IgG for zoster virus has been less sensitive & specific compared to PCR (more specific),[3] so, serological tests were not done. Patient has been initiated treatment with acyclovir as per standard regimen and has undergone even resolution with no complication and therefore diagnosis of HERPES ZOSTER is confirmed based on history & clinical picture in the present case.

TREATMENT

Usually orally administered acyclovir or other antiviral medicines viz. famciclovir & valacyclovir to be started within 72 hours of appearance of rash. Other drugs for symptomatic relief.[4]

CONCLUSION

Although appearance of classical vesiculopapular rash has been commonly observed in herpes zoster patients,



Rash in resolution : Day 06–Number -3 near left sternal border.

Number -4 near upper medial border of left scapula.

atypical presentation in herpes zoster patients is also found in both immunocompetent & immunocompromised individuals .Literature review revealed nodular rash in herpes zoster in immunocompromised patient.[5] Since present case is a otherwise immunocompetent person, therefore it is concluded that nodular skin rash may be presenting feature in herpes zoster in elderly persons i.e atypical presentation like other Geriatric illnesses.

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Bullous Pemphigoid in A Elderly Female with Diabetes: A Case Report

JAYANTA SHARMA* SHARMISTHA CHATTERJEE** PALLAVI BANERJEE***

Abstract

.....

Keywords: ...

CASE REPORT

A 78 yr old female presented with history of 3 weeks of fever with cough and cold for which she received Tablet Cefuroxime (500mg) for 5 days. She is a normotensive, with history of diabetes and Hypothyroidism on medication. She was complaining of itching on palms and soles, later she developed tense itchy blisters all over her body associated with skin peeling after ingestion of 5 days of medication

VITALS AND EXAMINATION

She was admitted in the ICU with cold, clammy skin, but she was alert, conscious and cooperative, Pulse-118/min, BP-80/60 mm Hg, CBG-336mg/dl and maintaining an SpO2 of 90% in room air

Chest examination revealed bilateral air entry was equal with occasional wheeze and abdominal examination showed abdomen to be soft, nontender.

General examination showed an elderly female with good built and multiple skin blisters associated with easy skin peeling all over body, including face, sole, palm.

INVESTIGATIONS

Post admission initial resuscitation was done and routine investigations revealed:

Hb-8.7 gm/dl,

TLC-19300(N 84 L10),

CRP-232/ ESR- 90

Serum Sodium- 124 meq/l,Serum potassium-2.6 meq/l, serum creatinine-0.7 mg/dl,

serum urea-33mg/dl SGOT- 82/ SGPT-96,

Urine RE: Plenty of pus cells

WORKING / Differential DIAGNOSIS:

ACUTE STEVEN JOHNSON SYNDROME

DRESS (Drug reaction with Eosinophilic and Systemic symptoms)

STAPHYLOCOCCAL SCALDED SYNDROME

BULLOUS PEMPHIGOID

PEMPHIGUS VULGARIS

SEZARY SYNDROME

Course In ICU/Hospital

Initially 3 days post admission her blood sugar was fluctuating with high grade fever and severe pain and tenderness of joints. She had difficulty in deglutition and congestion of oral cavity, throat with bilateral bronchospasm.

Regularly reviewed by dermatologist, pulmonologist, and ENT surgeon. Skin biopsy was taken from the affected area. On the 5th day onwards her blood sugar started normalising with remission in fever pattern & maintenance

*Senior Consultant, Head Internal Medicine & Critical Care, ** Intensive care Registrar In Charge, ***Registrar

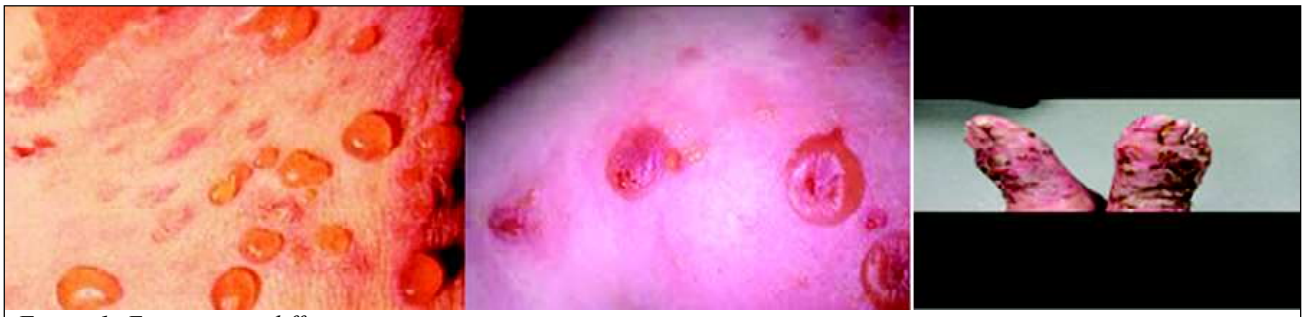

Figure 1: Eruptions in different stages

of SpO_2 and blood pressure. On the 7th day, skin biopsy from skin lesion demonstrated a subepidermal blister. The inflammatory infiltrate was typically polymorphous, with an eosinophilic predominance, suggestive of Bullous Pemphigoid.

FINAL DIAGNOSIS:

Bullous Pemphigoid

Uncontrolled Diabetes Type 2 Diabetes Mellitus

Urosepsis with

Respiratory Tract Infection

MANAGEMENT

Patient was admitted in ICU, treatment started aggressively with supplemental O_2 support, IV Fluids, symptomatically with regular insulin, iv antibiotics and other supportive measures to prevent superadded infections. She was reviewed by a dermatologist on an emergency who advised immediate skin biopsy from the affected area.

Her skin lesions were locally treated with NADOXYN CREAM, and she was started on Oral corticosteroids as per her body weight. Tab Dapsone-100 mg was also added and other supportive treatment with high protein and high calorie diet. She was put on tight glycaemic control and glucose level was normalised.

Her symptoms gradually subsided and she was discharged in stable condition after 22 days of intensive treatment, with advice for regular follow up.

CONCLUSION

Bullous pemphigoid (BP) is the commonest subtype of autoimmune blistering disease in most countries of the world. It occurs most frequently in elderly patients and is characterised clinically by large, tense blisters in the skin preceded by urticarial plaques and pruritus. Immunopathologically, it is characterised by autoantibodies directed against the 180 kD antigen (BP180) and the 230 kD antigen (BP230).

Bullous pemphigoid is a chronic autoimmune skin disorder resulting in generalized, pruritic, bullous lesions in elderly patients. Mucous membrane involvement is rare. Diagnosis is by skin biopsy and immunofluorescence testing of skin and serum. Topical and systemic corticosteroids are used initially. Most patients require long-term maintenance therapy, for which a variety of immunosuppressants can be used.

Bullae are elevated, fluid-filled blisters ≥ 10 mm in diameter.

Bullous pemphigoid occurs more often in patients > 60 yr but can occur in children. IgG autoantibodies bind to certain hemidesmosomal antigens (BPAg1, BPAg2), resulting in the activation of complement to form a subepidermal blister.

High-potency topical corticosteroids (eg, clobetasol 0.05% cream) should be used for localized disease and may reduce the required dose of systemic drugs.

Patients with generalized disease often require systemic treatment with prednisolone 60 to 80 mg po once/day, which can be tapered to a maintenance level of d" 10 to 20 mg/day after several weeks. Most patients achieve remission after 2 to 10 mo?, but treatment may need to continue for several years before the disease process remits enough to allow discontinuation. If long-term therapy is necessary, a new blister every few weeks does not require increasing the prednisolone dose.

Bullous pemphigoid occasionally responds to the anti-inflammatory activity of certain drugs, such as the combination of tetracycline or minocycline and nicotinamide. Other treatment options include monotherapy with dapsone, sulfapyridine, or erythromycin. IV immune globulin has been used occasionally. Clarify

For patients with generalized and recalcitrant disease, and sometimes to decrease corticosteroid dose in chronic disease, immunosuppressants such as methotrexate, azathioprine, cyclophosphamide, mycophenolate mofetil, and cyclosporine may be used. Among the biologics, rituximab and omalizumab may be used.

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News from West Bengal

2nd STATE CONFERENCE OF GSI WB BRANCH – 18th AUGUST 2019.

Geriatric Society of India West Bengal Branch organized its 2nd State Level Conference on Sunday, 18th August 2019 at Hotel Hindustan International, Kolkata. This

was one day scientific meeting with felicitation of some of the senior members. The conference was attended by 250 delegates. The Chief Guest of the conference was Spiritual Guru Smt. Dipa Devi. The conference was organized under the chairmanship of Dr. Chinmaya Kumar Maity. Dr. Krishnanjan Chakraborty & Dr. Anirudha De were the organizing secretaries. The Finance Secretary was Dr.

Mainak Gupta. The conference was conceptualized by Dr. Kaushik Ranjan Das.

WORLD ELDER'S DAY CELEBRATION

Geriatric Society of India West Bengal branch jointly with Barrackpore Elderly care Society celebrated World Elder's Day 2019 at CMDA Nagar Barrackpore on 01st October 2019.

The event was supported by IMA Titagarh Branch & other associations. The function was attended by more than 300 people. There were lectures, health check-ups, music & felicitations. Some daughter in laws & grand childrenen were felicitated for their care of elderly. All this was possible by the support & contribution from Dr. Chinmaya Kumar Maity, Dr. Krishnajan Chakraborty, Dr. R. N. Maity & Dr. Kaushik Ranjan Das.

News from Vijayapura

BASIC LEARNING COURSE IN GERIATRIC MEDICINE AND GERONTOLOGY

Basic Learning Course in Geriatric Medicine and Gerontology was organized at the Geriatric Clinic of Shri. B. M. Patil Medical College, Hospital & Research Centre, BLDE (Deemed to be University), Vijayapura

Dr. Vijay Kumar K, Medical Superintendent inaugurated the function by lighting the lamp along with Dr. Badier S HOD Medicine, Dr. RM Honnutagi, Deputy Medical Superintendent, Dr. VG Warad Assistant Medical Superintendent, Dr. Deeksha, Dr. Pooja and Dr. Rinto on 12th July 2019 in Dr. BC Roy Seminar Hall.

Dr. Anand P. Ambali course coordinator welcomed the dignitaries, PG students and interns of pharmacy college. He said this course is second in series, has been approve by BOS of the University and the syllabus is as per MCI recommendations.

Dr. Sonam R, PG read the report of geriatric clinic. Dr. Pranav student of previous batch gave his feedback regarding the course.

Dr. Vijaykumar K appreciated the activities of the geriatric clinic and assured all the assistance from his office towards academic activities. He also said such sensitization programs are need of the hour.

Dr. Badiger Sharanabasawappa, HOD Medicine congratulated Dr. Anand and appreciated the activities of the geriatric clinic. He opined that such courses will empower our post graduate students to approach the older people in a better way. He urged all the newly enrolled twelve students to make best use of this course.

Dr. S M Biradar, Associate Professor, College of Pharmacy, Dr. S P Chaukimath, HOD of Department of Psychiatry who are faculty for this course were also honoured. Thirty delegates participated in the program. Dr. Ambali gave away the vote of thanks.

CONGRATULATIONS

Congratulations **Dr. Sandeep Tamane for receiving Fellowship of Royal College of Physicians of Edenborough on 8th November 2019 at the RCPE.*

VACCINATION PROGRAM

Forty-Five Senior citizens received Influenza Vaccine to prevent Pneumonia on 20th October 2019. Influenza vaccine is recommended by WHO, CDC & Geriatric Society of India for all senior citizens, once every year in the winter season. In our commitment towards preventive care for senior citizens, this is third mass campaign in last four years. Thanks to Mr Mali Patil of Universal Biotech, Dr. Raju Talwar, Mr Ningaraj, Mr Sudhakar, Mrs Geeta & Mrs Premabai for their assistance & senior citizens for their participation. This camp was held in Anand Hospital, Vijayapura.

TRAINING COURSE ON GERIATRIC CARE

Forty ANM & 60 ASHA workers received training in a program organized by the Kalike Trust, TATA Trusts, NHM, Govt. of Karnataka, NPHCE, DHO, DSO & THO of Yadgir & St Johns Bangalore. Four PHC's were adopted in Yadgir District on pilot basis to provide training to the medical officers, ANM, ASHA & Mentors of Yadgir District regarding health care of older people. Geriatric Clinic at Shri. B. M. Patil Medical College, Hospital & Research Centre is selected to provide training, consultancy, Advocacy and preparing care providing modules.

The program was organised on 20th – 21st September 2019 at AYUSH Bhavan for ANM and ASHA workers respectively.

The training session of 4 hours each included

Comprehensive Geriatric assessment, communication, common problems identification and prevention of diseases in older people, Elder abuse and note on NPHCE.

Dr. Vivekanand Tenge DSO of Yadgir inaugurated the program & Dr. Shrikanth Kalaskar Program officer from TATA Trust presided and supervised the program for two days.

CONGRATULATIONS

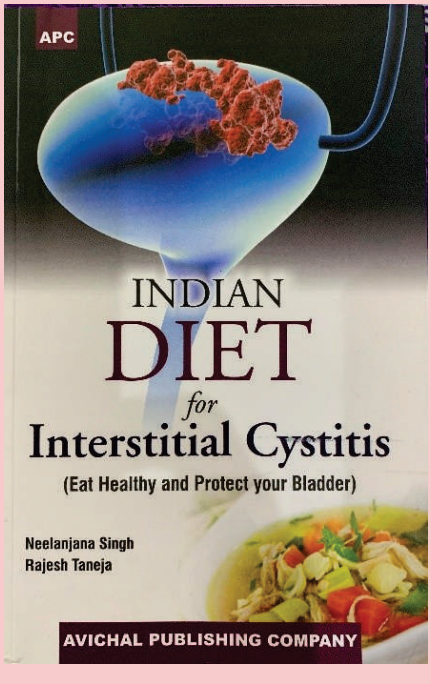
*Congratulations **Dr. Bindu Menon** for being conferred upon Fellowship from Indian Academy of Neurology from the President, Indian Academy of Neurology, Dr. Satish Khadilkar.*

*Congratulations **Dr. Bindu Menon,** Senior Neurologist, Apollo Speciality Hospitals - Nellore for being awarded Sakshi Excellence Award in Health Care on 10th August 2019 at Hyderabad.*

Book Review

Indian Diet for Interstitial Cystitis by Dr. Rajesh Taneja

Interstitial Cystitis, also known as Bladder Pain syndrome is a disease that causes intense bladder pain and frequent visits to washroom. This is primarily due to an unusually sensitive bladder which gets irritated by the presence of urine. Since contents of urine can be correlated with what one eats, modifications in diet become integral part of management of these patients. The internet is overwhelmed with material on this issue and most Indian patients feel lost as the information available is primarily on the western diet. This book is an attempt to help patients of Indian origin who need guidance to modify their diet to reduce the misery caused by this dreadful disease. However, the benefits of the contents of this book are not limited to patients with Interstitial cystitis alone, but are also useful for people suffering from other disease of urinary bladder as well, like chronic infections and overactive bladder.



*Congratulations to the Fellows of Geriatric Society of India for the year 2019.

- Dr. Anil Suchak
- Dr. Jayesh Lele
- Dr. Bijal Vora
- Dr. Sanjiv Maniar
- Dr. Pratibha Periera
- Dr. Puneet Saxena
- Dr. Sher Singh Dariya
- Dr. Sachin Desai
- Dr. Mohit Saran
- Dr. Ketan Mehta
- Dr. Rajendra Prasad

*Congratulations to the awardees of Orations for the year 2019.

Dr. Agam Vora	***Presidential Oration***
Dr. A. K. Singh	***Bamacharan – Hemlata Dhar Oration***
Dr. Bindu Menon	***Dr. J. J. Rao Oration***
Dr. V. K. Arora	***Prof. K. C. Mohanty Oration***
Dr. Sunil Kaul	***Sri Sunku Subrahmanyam Memorial Oration***

FORTHCOMING ACTIVITY

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Kolkata

Conference in Mysore
Last Week of
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