IJGC

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HIGHLIGHTS

Announcement

Geriatric Society of India West Bengal Branch

(Under the aegis of GSI WB Institute of Training, Education and Research (GWITER)- Established by a resolution of the registered body, Geriatric Society of India West Bengal Branch)

Launching Soon!

Geriatric Social Worker (Caregiver) Training Programme

(Pre-recorded online video training programme)

Course Duration – 06 (Six Month)

Eligibility - Pan India, 10+2 Passed and above

(Under exceptional cases educational qualification can be lowered)

Medium of Study: English

Course Fee: 1000/-

Inclusive of a copy of "A guide for a Geriatric Social Worker Caregiver)

Invited Faculty: Pan India GSI Members and also non-Medicos.

Contact:
Dr. Kaushik Ranjan Das (krdas58@yahoo.co.in)

Announcement!!

GSICON 2022

2nd, 3rd & 4th December 2022
at
Biswa Bangla Convention Centre
Kolkata
Contact:
Dr. Kaushik Ranjan Das (krdas58@yahoo.co.in)

Editorial Board

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GSI News

Dr. Anand P. Ambali
Guest Editor

Post COVID scenario in Elderly

Elderly people are feeling in-secured about their life and have developed mental and physical decline following COVID 19 infection. The elderly suffered not only health issues, but they lost social contacts and were subject to Abuse in their own home. Now the fact that the scenario has changed, most of the healthy elderly are back to their routine while those who had developed severe COVID and had complications are living with bereavement, reduced physical strength and poor mental wellbeing. This has created negative impact on their quality of life. The role of counselling, physiotherapy and rehabilitation must continue at various levels to ensure the elderly too join the main stream. The most important intervention will be improving lung function which in turn make the elderly keep moving. Breathing exercises, yoga, daily balloon blowing and to stop smoking are the few measures recommended to improve lung function.

The COVID has not spared any organ in the body. The Long 'Post COVID Syndrome' is defined as the signs and symptoms that develop during and after an infection consistent with COVID, continue for more than 12 weeks and are not explained by alternate diagnosis. The Government of India has brought out booklet on NATIONAL COMPREHENSIVE GUIDELINES FOR MANAGEMENT OF POST COVID SEQUELAE, Ministry of Health and Family Welfare.[1] It is a must-read book which has discussed in detail the involvement of various organs of the body and its sequalae to COVID 19.

Now the elderly people are seeking job to support their family and are looking for offers. Many NGOs are conducting job fairs and are helping the needy to get the job who in-turn can support their family. For this they need to have a good physical and mental health.

The COVID 19 vaccine has played important role in prevention of COVID and Its complications in the elderly population across the country. It was the elderly who reached the Vaccine centre in large numbers. This speaks of their maturity and responsibility towards family in preventing the spread of COVID. Our study on safety of COVID 19 vaccine in 1373 elderly has endorsed the COVID 19 Vaccines are safe in elderly population despite having multiple co-morbidity.[2] The precautionary dose of vaccine is also well received and because of which many new cases are prevented. This has also helped in preventing complications in elderly population.

The short communication by Samajdar S. S. et al, on Yoga in Elderly and COVID 19 has in- fact covered wider aspect of role of Yoga in keeping our elderly physically and mentally active and overcome the stress in an effective manner. I feel the initiatives mentioned should be generalised to the elderly population in large scale and in many cities.

The prevention of pressure sores in elderly is of paramount importance. Dr. Vigneshwaran has shared Do's and Don't's of pressure sores which needs to be practiced by all of us and prevent mortality. The most important discussion on End-of-Life Care is been written by Dr Garima Handa which discusses various challenges and the solutions.

Loss of hairs to loss of libido are among many issues that has a negative impact on Quality of Life of Elderly. We as the clinicians need to take a further step wherein, we can identify and prevent the complications and prevent a disability. We should be part of solutions and say no to Ageism.

Let us start preparing to organise events to commemorate World Alzheimer's Day on September 21, International Day for Older People on October 1, World Hospice and Palliative Care Day on October 8, 2022.

I also take this opportunity to invite you all to actively participate in GSICON 2022 to be held on 3 & 4 December, 2022 at Kolkata.

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Dr. Anand P. Ambali
Professor,
Geriatric Clinic, BLDE DU, Shri B M Patil Medical College Hospital and RC,
Vijayapura. Karnataka.

Hypoglycemia In The Elderly

Dheeraj Kapoor*, Gaurav Vashist, Bidyut Banerjee****

Abstract

Diabetes in the elderly population is growing into epidemic proportions throughout the world. Though there are some disease similarities in older and middle-aged people, understanding the pathophysiology, clinical features and treatment of the elderly diabetic population presents additional challenges. Tight metabolic control should be the goal of therapy, but may not be safe in all the elderly patients because of co-morbidities and risk of hypoglycemia. Long acting sulphonylureas should be avoided because of the risk of hypoglycemia. The majority of the elderly may ultimately require insulin to achieve acceptable metabolic control. Whether on insulin or on oral drugs, self-monitoring of blood glucose will help reduce the risks of serious hypoglycemia. Targets of glycemic control have to be determined with due consideration to age, remaining life expectancy, comorbid conditions and severity of vascular complications. Further studies are required to delineate the exact etiology of glucose intolerance and to make age-specific treatment recommendations.

Keywords: *Hypoglycemia, Glycemic threshold, neurology*

INTRODUCTION

Approximately half a billion people are living with diabetes worldwide, which means that over 10.5% of the world's adult population now has T2DM. Currently, around half of the patients with T2DM are over 65 years of age. The number of older people with diabetes is expected to increase as the population continues to age and as diabetes treatment continues to improve. Treatment of older adults with type 2 diabetes (T2D) is complex because they represent a heterogeneous group with a broad range of comorbidities, functional abilities, socioeconomic status, and life expectancy.

Aging and changes in the physiologic reserves generate a decreased perception of symptoms associated with hypoglycemia, increasing the risk of unawareness or severe episodes. The exact incidence of hypoglycemia in older patients with diabetes is difficult to estimate because of a limited number of clinical trials in this age group and the heterogeneity of this population. As a result, hypoglycemia in elderly is not only under diagnosed but also under reported. Nevertheless, older adults with diabetes have a greater risk of hypoglycemia and suffer greater adverse consequences from such events than younger individuals. Consequences of hypoglycemia include acute and long-term cognitive changes, cardiac arrhythmia and myocardial infarction, frailty, serious falls, often resulting in hospitalization, or even death . Thus, clinical management must balance optimizing glycemic control with minimizing hypoglycemia risk. The major goal, especially in care of the older or more debilitated population is the maintenance of glucose levels below those that cause symptomatic polyuria and polydipsia rather than a specific HbA1c target.

* Chief of Endocrinology, Artemis Hospitals, Gurugram
**Artemis Hospitals, Gurugram

DEFINITION

Hypoglycemia is defined by an arbitrary plasma glucose level of <3.9mmol/l (<70 mg/dL) which is the level below which activation of the counter-regulatory hormone response occurs in most adult subjects. But, the glycemic threshold for hypoglycemia and for counter-regulatory responses can vary markedly, not only among different patients (for example, between those receiving insulin or insulin secretagogues and those who are not) but also within the same patient at different times depending on their glycated hemoglobin (HbA1c) levels and previous hypoglycemia episodes. The glycemic threshold for hypoglycemic symptoms is higher in those with poor glycemic control and infrequent hypoglycemic episodes, and is lower in those with good glycemic control and more frequent hypoglycemic episodes. Thus, it is insufficient to use one specific glucose level to define hypoglycemia. Thus, the American Diabetes Association (ADA) defined iatrogenic hypoglycemia as 'all episodes of an abnormally

low plasma glucose that expose the individual to potential harm'[1]

Subsequently, new recommendations as per a joint position statement from the International Hypoglycemia Study Group of the ADA and the European Association of the Study of Diabetes (EASD), which are also reflected in the updated ADA standards of medical care in diabetes released in 2021, established the following three levels for blood glucose concentration:

Level 1: hypoglycemia alert value; <70 mg/dL (3.9 mmol/L): may or may not be accompanied by symptoms; asymptomatic hypoglycemia if symptoms not present

Level 2: clinically significant hypoglycemia; <54 mg/dL (3.0 mmol/L)

Level 3: severe hypoglycemia. No specific glucose threshold: hypoglycemia associated with severe cognitive impairment requiring external assistance for recovery.[2]

CAUSES

Nutritional discordance

Overtreatment of DM - Higher blood sugar and HbA1c targets should be acceptable in the elderly because the benefits of tight glycemic control are accrued over several years which may not be equally relevant in individuals with lesser life expectancy.

Intensive (or complex) Regimens - Often severe hypoglycemia was observed in the ACCORD trial (the Action to Control Cardiovascular Risk in Diabetes) involving 10,251 patients with uncontrolled type 2 diabetes (HbA1c = 8.1%) and high risk or diagnosed cardiovascular disease. In the group treated intensively, in which the aim was to reduce HbA1c below 6%, severe hypoglycemia occurred in 16% of patients (3% /year). Particularly high risk for severe hypoglycemias were observed in patients with type 2 diabetes treated intensively (aim – HbA1c below 6%) in the study of the Veterans Affairs Diabetes Trail (VADT). This study included 791 patients with uncontrolled diabetes (HbA1c at baseline 9.4%). The 6-year follow-severe hypoglycemia occurred in 21% of intensively treated patients.[3,4]

Infection -Infections, are often attributed as a cause of hyperglycemia. Hypoglycemia however may be a part of suppressed appetite clubbed with a mismatch of OADs or insulin dosage, or as a part of sepsis (depleted glycogen reserves, impaired gluconeogenesis and increased peripheral glucose utilization) and organ dysfunction, or be induced by drugs used for treating the infection.

Hepatic dysfunction -Liver injury is one of the causes of hypoglycemia. The major case of acute liver failure is hepatitis virus infection or drug-induced liver damage, but in many cases, the cause of liver failure remains unknown. NAFLD is also emerging as a cause of cirrhosis.The management of diabetes in liver disease can be challenging. There is difficulty in diagnosis and monitoring of diabetes as fasting blood sugar values are low and glycosylated hemoglobin may not be a reliable marker. The challenges in the management of diabetes in cirrhosis include the likelihood of cognitive impairment, risk of hypoglycemia, altered drug metabolism, frequent renal dysfunction, risk of lactic acidosis, and associated malnutrition and sarcopenia. Moreover, calorie restriction and an attempt to lose weight in obese diabetics may be associated with a worsening of sarcopenia. Many commonly used antidiabetic drugs may be unsafe or be associated with a high risk of hypoglycemia in a patient with cirrhosis. Post-transplant diabetes is common and may be contributed by immunosuppressive medication.

Renal dysfunction -Hypoglycemia associated with renal failure is more common than generally thought. In fact, hypoglycemia should be suspected in any patient with renal failure who exhibits any change in mental or neurologic status. In the evaluation of uremic hypoglycemia, the first step should be the exclusion of obvious causes such as insulin, oral hypoglycemic agent therapy, and the use of drugs known to cause hypoglycemia. Propranolol, salicylates, and disopyramide are among the most commonly implicated agents. Additional triggering events are alcohol consumption, sepsis, chronic malnutrition, acute caloric deprivation, concomitant liver disease, congestive heart failure, and an associated endocrine deficiency. When no obvious cause can be demonstrated, the hypoglycemia is referred to as spontaneous. Spontaneous uremic hypoglycemia has been attributed to deficiency of precursors of gluconeogenesis. However, the mechanism(s) seems to differ from one patient to the other. Dialysis also predisposes to hypoglycemia in uremia, possibly because of the chronic state of malnutrition. Post dialysis hypoglycemia is secondary to glucose-induced hyperinsulinemia, which is caused by the high glucose content in the dialysate.

The challenges of glycemic management in elderly

Treatment of older adults (≥ 65years) with diabetes is complex because they are a heterogeneous group with a broad range of comorbidities (e.g. CVD, visual impairment, arthritis), functional disabilities (e.g. mobility, eating, personal hygiene), socioeconomic influences (e.g. education, income, living accommodations), and life expectancy.

When blood glucose levels fall, insulin release is suppressed, and counter regulatory hormones, such as glucagon and epinephrine, are activated to stimulate hepatic glucose production and inhibit peripheral glucose uptake until euglycemia is restored. In adults with diabetes, this counter-regulation is defective: there is a loss of ability to decrease insulin production and to increase glucagon

release, combined with an attenuated increase in epinephrine.[1] The response by older adults to a drop in glucose appears to depend on how frequently they experience hypoglycemia.[1] Recurrent hypoglycemia reduces the glucose level at which the counter-regulatory response occurs; consequently, patients with frequent hypoglycemia experience symptoms from the adrenergic response to a decrease in blood glucose at lower glucose levels. In some instances the glucose level that triggers the counter-regulatory response is below the glucose level associated with neuroglycopenia, also called hypoglycemia unawareness, and results from attenuated increases in sympatho-adrenal activity. The combination of a defective counter-regulation with hypoglycemia unawareness is called hypoglycemia-associated autonomic failure, and is caused most often by prior hypoglycemic episodes.[1]

Polypharmacy, which is more common in the elderly due to the greater occurrence of multiple chronic clinical conditions, may increase the risk of severe hypoglycemia, especially when patients are on sulfonylureas. Additionally, age-related changes in pharmacokinetics and pharmacodynamics have the potential of increasing the adverse effects of polypharmacy in this patient population.[6] Older adults are also at an increased risk of hypoglycemia due to numerous clinical conditions, including decreased hormonal regulation and counter-regulation, suboptimal intake of water and/or food, decreased intestinal absorption, and cognitive impairment.[7] The elderly tend to present with neuroglycopenic symptoms (i.e. dizziness, visual disturbances, increased agitation, and/or confusion) rather than adrenergic symptoms (i.e. palpitations, sweating, tremors) These symptoms may be caused by other conditions, particularly in the elderly, such as increased agitation, and/or confusion, may be confused with dementia-related symptoms, while symptoms such as dizziness or visual disturbances may be misdiagnosed as stroke, or vertigo. Finally, both cardiovascular (CV) disease,[8,9] and CKD[10] have been shown to be strong risk factors for hypoglycemia in older adults.

With increasing unidentified cognitive impairment in the elderly, there may be difficulty in adhering to complex self-care activities (e.g., glucose monitoring, titrating doses of insulin or OADs as per skipped meals or sick days).

MANAGEMENT

Although the overall treatment goals for diabetes management in older adults are similar to those in younger people, glycemic targets need to be more flexible for the former population.

There have been no randomized trials on the benefits of tight glycemic control in older patients. However, experience from some of the larger trials of diabetes control which also included a large component of senior citizens seems to show that such benefits do exist. The following general guidelines can be used while considering treatment options in elderly individuals.

- Older adults who are functional, cognitively intact and have significant life expectancy should be treated using goals developed for younger adults
- Glycemic goals can be relaxed and individualized for patients not meeting the above criteria. In this situation, insulin regimens can be simplified and treatment "de-intensified".
- In all cases, complications like dehydration, delayed wound healing and HHS should be avoided.
- Treatment of other CV risk factors (BP, lipids) should also be undertaken. In fact, there is good evidence for the benefits of tight BP control in elderly patients

Anti-diabetic therapy for those with CKD require individualization. Accuracy and precision of HbA1c measurement declines with advanced CKD (G4–G5), particularly among patients treated by dialysis, in whom HbA1c measurements have low reliability. Therefore, continuous glucose monitoring (CGM) data can be used to index glycaemia for individuals in whom HbA1c is not concordant with directly measured blood glucose levels or clinical symptoms. For patients with type 2 diabetes (T2D) and CKD who choose not to perform daily glycemic monitoring by CGM or SMBG, anti-hyperglycemic agents which pose a lower risk of hypoglycemia are preferred and should be administered in doses that are appropriate for the level of eGFR.

The effective control of hyperglycemia may reduce complications and mortality rate in patients with DM and chronic liver disease. Most patients will require oral hypoglycemic agents and/or insulin to control hyperglycemia, especially in advanced stages of liver disease. But, satisfactory glycemic control in cirrhotic patients can be achieved in only one third of cases by using current therapeutic schemes possibly because of hepatotoxicity, hypoglycemia and lactic acidosis, as most of antidiabetic drugs are metabolized in the liver. Insulin requirements can be high in patients with compensated cirrhosis, whereas they can be low in decompensated patients due to a reduction in hepatic clearance and gluconeogenesis. Because of this, it is recommended that the administration of insulin in patients with cirrhosis should start with close monitoring due to the risk of hypoglycemia. The pharmacokinetic of short-acting insulin analogues such as insulin lispro, aspart and glulisine is not significantly altered in hepatic dysfunction; thus, these agents are useful for controlling postprandial hyperglycemia. Modern insulins with an ultra-long lasting effect have a stable

Patient characteristics/ health status	Rationale	Reasonable A1C goal‡	Fasting or pre-prandial glucose	Bedtime glucose	Blood pressure	Lipids
Healthy (few coexisting chronic illnesses, intact cognitive and functional status)	Longer remaining life expectancy	<7.0–7.5% (53–58 mmol/mol)	80–130 mg/dL (4.4–7.2 mmol/L)	80–180 mg/dL (4.4–10.0 mmol/L)	<140/90 mmHg	Statin unless contraindicated or not tolerated
Complex/ intermediate (multiple coexisting chronic illnesses or 2+ instrumental ADL impairments or mild-to-moderate cognitive impairment)*	Intermediate remaining life expectancy, high treatment burden, hypoglycemia vulnerability, fall risk	<8.0% (64 mmol/mol)	90–150 mg/dL (5.0–8.3 mmol/L)	100–180 mg/dL (5.6–10.0 mmol/L)	<140/90 mmHg	Statin unless contraindicated or not tolerated
*Very complex/ poor health (LTC or end stage chronic illnesses** or moderate-to severe cognitive impairment or 2+ ADL impairments)*	Limited remaining life expectancy makes benefit uncertain	Avoid reliance on A1C; glucose control decisions should be based on avoiding hypoglycemia and symptomatic hyperglycemia	100–180 mg/dL (5.6–10.0 mmol/L)	110–200 mg/dL (6.1–11.1 mmol/L)	<150/90 mmHg	Consider likelihood of benefit with statin

ADL, activities of daily living; LTC, long-term care.
‡ A lower A1C goal may be set for an individual if achievable without recurrent or severe hypoglycemia or undue treatment burden.
* Coexisting chronic illnesses are conditions serious enough to require medications or lifestyle management and may include arthritis, cancer, congestive heart failure, depression, emphysema, falls, hypertension, incontinence, stage 3 or worse chronic kidney disease, myocardial infarction, and stroke. "Multiple" means at least three, but many patients may have five or more
** The presence of a single end-stage chronic illness, such as stage 3–4 congestive heart failure or oxygen-dependent lung disease, chronic kidney disease requiring dialysis, or uncontrolled metastatic cancer, may cause significant symptoms or impairment of functional status and significantly reduce life expectancy. Adapted from Kirkman et al.

pharmacokinetic profile. They show no differences with respect to drug absorption or clearance in cirrhotic patients. No serious adverse effects, such as hypoglycemia, have been observed when using these class of insulins in patients with cirrhosis.

Treatment of Hypoglycemia Episode

Treatment of hypoglycemia should be immediate to prevent brain damage. Attempts should be taken to document the blood sugar level, but treatment should not be delayed if symptomatic hypoglycemia is suspected in the absence of rapid blood glucose testing.

In-hospital care is to be considered for all elderly hypoglycemic patients with severe hypoglycemia, ingestion of a long-acting hypoglycemic agent, recurrent hypoglycemia during observation, and those unable to eat. The patient should be observed for 24–48 hours, depending on the etiology. Cerebral edema or stroke should be suspected if the patient does not become conscious inspite of achieving euglycemia.

Increasing the blood sugar to hyperglycemic range does not correct hypoglycemia quickly; moreover, hyperosmolar glucose solution damages the brain under stress. The aim of blood sugar level should be 90–140 mg/dL. For mild hypoglycemia, 10–20 g of glucose or an equivalent snack is sufficient. For severe cases, the amounts of IV dextrose solution to achieve 90–140 mg/dL are as follows:

- 50% dextrose = 0.5 mL/kg of body weight (BW)
- 25% dextrose = 1.0 mL/kg BW
- 10% dextrose = 2.5 mL/kg BW

Measure blood glucose 10 to 15 minutes after the IV bolus, re-administer 12.5 to 25 grams of glucose as needed to maintain the blood glucose above 80 mg/dL and monitor every 30 to 60 minutes thereafter until stable (minimum of four hours). The measurement method should provide rapid turnaround, preferably at the point of care.

Oral feeding should be started once the patient becomes conscious and glucose omitted. Once the patient is able to ingest carbohydrate safely, providing a mixed meal (including carbohydrates, such as a sandwich) is the preferred means of maintaining glucose levels.

Older patients can also be stratified for future risk of hypoglycemia with validated risk calculators (e.g., Kaiser Hypoglycemia Model)

CONCLUSION

Older adults are at an increased risk of hypoglycemia due to numerous clinical conditions. Optimal glycemic control in the elderly, though challenging, can only be achieved by individualized management approaches that take into account the patient's clinical characteristics (including body weight, comorbidities, and life expectancy), social circumstances (living in the community alone/with family, resident in a nursing home), personal preferences, and level of health insurance coverage. Physicians and their older patients with diabetes must make treatment decisions that best serve the individual's circumstances. Thus, glycemic goals can be relaxed as part of individualized care, but symptomatic hyperglycemia must be avoided..

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Vaccination in Geriatric People

Kaushik Ranjan Das*

We (geriatrician / Geriatric Physicians) have been working in an era where a programme in the name "Decade of Healthy Aging" from 2021-2030, has been launched under implementation by WHO, as a programme of United Nations. WHO defines Healthy Ageing "as the process of developing and maintaining the functional ability that enables wellbeing in older age". Healthy lifestyle includes nutritious diet, work, appropriate physical exercise, strategy for preventive healthcare, the interaction with the environment, and social connectivity ; therefore healthy life style practices in senior citizen plays crucial role in their healthy living.[1] Among the healthy life style practices vaccination in Geriatric age group can prevent diseases and subsequent complications that can lead to long term illnesses, hospitalization and even death. As a consequence of homeostenosis, immunosenescence occurs and as a result elderly faces difficulty in fighting against infections.

Decreased immunity in elderly also occurs due to comorbidities like diabetes, heart and kidney diseases, cancers, and also by drugs and procedures required to manage disease conditions etc. Vaccines can protect elderly from some diseases , can decrease complications of diseases, thereby decreasing morbidity , mortality& health care expenditure provides enhanced quality of life and graceful healthy aging. Geriatric Society of India has reasonably thought of the situation and started working on that more than a decade back. Under the able guidance of Dr. P. S. Shankar, GSI has brought out Guidelines for the use of Pneumococcal Polysaccharide Vaccine in India – 2008, Indian Guidelines for Vaccination in Older Adults – 2012 & Indian Recommendations for Vaccination in Older Adults – 2015.[2] In the year 2014 in the first conference of its kind, Dr. O. P. Sharma invited pediatricians, physicians & geriatricians to do a conference on Vaccination – womb to tomb & produced "Vaccines at a Glance". This book covered all the vaccines given to human beings at various ages.

Taking information from "Vaccine at a Glance" and other sources a snap shot on Geriatric Vaccination has been articulated as follows-

1. Influenza vaccine : Yearly, Single dose ,I/M over deltoid
   Brands :Influvac Tetra 2022 (Abbott). Contraindicated in people allergic to egg.
   ** Flublok quadrivalent is cell based and egg free
2. Pneumococcal Vaccine : Conjugate Vaccine , single dose above 55 years ,I/M over Deltoid , may be given in same sitting with influenza vaccine in other deltoid.
   Brands : Prevnar13 (Pfizer) .
   Pneumococcal polysaccharide vaccine : Above the age of 55years, single dose, may be repeated after 5 years.I/M, (deltoid) May be given in same sitting with Influenza vaccine.
   Pneumococcal conjugate vaccine & polysaccharide vaccine cannot be given in same sitting. The two are given one year apart (irrespective of type of vaccine) in immunocompetent & 2 months apart in immunocompromised persons (CDC guideline).
   Brands : Pneumovax23(Merck) , Pulmovax 23(Lupin).
3. Herpes Zoster : Single dose ,subcutaneously over deltoid (not I/M) over the age of 60 yrs. Not in immunodeficiency state, past history of anaphylaxis, bronchial asthma exacerbation & polymyalgia rheumatica. Brand : Zostavax single dose. SHINGRIX 02 doses,2-6 month interval.
4. Tetanus , Diphtheria & Pertussis : Td/Tdap vaccine at every 10 years in previously vaccinated persons.[3] At 01,02 & 06 month in unvaccinated .
5. Hepatitis B : For unvaccinated in normal person 20mcg I/M on 0,1, & 06 month . All CKD patients should receive a dose of 40 mcg 0,1,2 & 6month

*Consultant Family Physician and Geriatrician, Nehru Memorial Technoglobal Hospital, Barrackpore, Kolkata

(CDC recommendation).[4] Brands: Hepaccine B (Bharat serum), Engerix B (Glaxo).

6. Varicella: 02 doses 01 month apart,I/M(for unvaccinated) Brands-Varilrix, Zuvicella (Zuventus).
7. Rabies Vaccine : According to dose schedule.

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2. https://www.geriatricindia.com
3. https://www.cdc.gov>vaccines>adult
4. www.ncbi.nlm.nih.gov

MATCH THE FOLLOWING

Dr. Anand P. Ambali

1.	World Elder Abuse Awareness Day	a)	October 01
2.	World Alzheimer's Day	b)	November 14
3.	World Parkinson's Day	c)	November 12
4.	World Pneumonia Day	d)	March 24
5.	International day for older people	e)	June 15
6.	World Osteoporosis Day	f)	April 11
7.	World COPD Day	g)	September 21
8.	World Diabetes Day	h)	May 17
9.	World Tuberculosis Day	i)	November 16
10.	World Hypertension Day	j)	October 20

For answers see the last page

Yoga in Elderly and COVID 19 – A Short Review

Shambo S Samajdar[1], Shatavisa Mukherjee[2], Santanu K Tripathi[3], Jyotirmoy Pal[4], Shashank R Joshi[5]

Yoga is a mind-body technique serving as a holistic lifestyle, which has originated in ancient India. The word 'yoga' means union, symbolizing union of individual consciousness with the universal divine consciousness. Yoga has been an effective therapeutic measure promoting physical, mental, social and spiritual wellbeing.[1] Various studies have suggested beneficial role of Yoga in improving cardiovascular risk factors like body weight, lipid profile, blood pressure, smoking, psychosocial stress and type 2 diabetes mellitus.[2-5] With growing evidences, yogic postures and practices have made a strong mark in various clinical practices, where it has been presented as an alternate prescription. As per American Heart Association (AHA), Transcendental meditation techniques may be prescribed for controlling blood pressure and it could decrease heart attacks, stroke and deaths in CVD patients.[6] Studies in form of randomized clinical trials have even suggested that regular practice of Yoga and meditation, have significantly reduced carotid intimal medial thickness.[7,8] Yoga also has demonstrated its beneficial role in pulmonary disorders. An observational study found that Om chanting in addition to conventional pharmacotherapy has a beneficial effect in COPD patients.[9]

COVID 19 related morbidity and mortality have increased due to coexisting comorbidities like cardiovascular disease, diabetes, COPD etc. Moreover, increased age has been a constant risk factor in our fight with COVID-19. Thus, yoga in addition to conventional therapies has been an important medium to address these comorbidities in better way, especially in the elderly, who are more vulnerable to adversities. COVID 19 is multisystem involved disease where associated complications are related to hyper inflammatory responses. Stress, anxiety, depression, frustration, uncertainty during COVID-19 outbreak has been a common manifestation among patients.[10] Such psychological stress has also been a risk factor for the elderly population, who were pre-burdened with allied comorbidities. At such outset, mindfulness and yoga have proven beneficial effects in ameliorating mental stress. A systematic review and meta-analysis including forty two studies had suggested beneficial effect of yoga in improving sympathetic nervous system regulation and hypothalamic-pituitary-adrenal system in various populations.[11] Yoga would provide reduction in stress in community and COVID 19 patients and help us to fight against this pandemic. Stress and anxiety indirectly decrease immunity and make human more susceptible to infection. Yoga could help us to fight against this by deleting sadness and adding up happiness.

As an add-on to anti-tuberculosis drug therapy in sputum-positive cases of pulmonary tuberculosis patients, efficacy of integrated yoga including asanas, breathing practices, relaxation techniques, and meditation had helped in achieving earlier ($P < 0.05$) sputum negativity in the yoga group as compared to control group.[12] Patient living with HIV (PLHIV) infection were intervened with integrated yoga and it had been seen that there was a significant reduction in viral load with an increase in the number of CD4 T cells after one month and there was marked improvement in psychological states of PLHIV.[13] In another study alpha brain activation in frontal lobe was found to be significantly correlated with increase NK cell activity during yoga.[14] Yoga helps in mental wellbeing which also

1. Clinical Pharmacologist, Department of Clinical Pharmacology, School of Tropical Medicine, Kolkata, West Bengal, India & Consultant, Diabetes & Allergy-Asthma Therapeutics Clinic, Kolkata
2. Department of Clinical & Experimental Pharmacology, School of Tropical Medicine, Kolkata, West Bengal, India
3. Consultant Clinical Pharmacologist & Academic Dean and Prof & Head, Department of Pharmacology, Netaji Subhas Chandra Bose Medical College and Hospital, Patna, Bihar, India
4.Professor, Department of Medicine, RG Kar Medical College and Hospital, Kolkata, West Bengal, India
5. Senior Endocrinologist, Joshi Clinic, Mumbai, Maharashtra, India

improves cellular immunity. Yoga practices promote anti-inflammatory and typically reduce pro-inflammatory cytokine activity.[15] Another study had suggested 6 weeks of 20-min daily mindfulness meditation leads to a significant decrease in activity of the pro-inflammatory transcription factor nuclear factor kappa B (NF-κB) and an increase of anti-inflammatory glucocorticoid receptor activity and reductions in circulating levels of C-reactive protein (CRP) and IL-6.[16] Increased level of IL6 is observed in cytokine storm, Yoga having IL6 reducing property could be beneficial in preventing it. The beneficial effects of yoga on innate immune system have also been showed in a study demonstrating that 90 min of yogic asana would increase expression of β-defensin and HBD-2 expression.[17] These two peptides present in respiratory epithelial cells are beneficial to fight against virus.[18] Yoga therapy has also been demonstrated downregulating tumor necrosis factor receptor and IL-1 receptor, and stress associated CRP.[19] Another clinical study had demonstrated that combined mantra-based meditation and yoga asana practices regulated pro inflammatory cytokine TNF-α level and metabolism of the Alzheimer's disease-associated amyloid-β protein, and also showed reduction in expression of pro-inflammatory genes in association with a meditation practice.[20] These studies had suggested anti-infective role of Yoga. Anti-inflammatory role of Yoga by diminishing IL6 level, anti IL1 and anti TNF alpha activity could be beneficial to prevent or limit inflammatory cascade and related complications in COVID 19. Viral attachment to respiratory epithelium would be blocked by Yoga due to increased β-defensin expression.

It had been demonstrated that Yoga training improved expiratory and inspiratory muscles strength.[21] Another study had shown that a 6-week course of pranayama had a beneficial effect on ventilatory lung functions.[22] Improvement in respiratory parameters could be beneficial for COVID 19 patients. Expiratory and inspiratory muscular strength has better capacity to prevent pulmonary damage by SARS CoV2 virus. Recovery from post COVID 19 complications in lungs and compromised ventilatory function would be fastened by the virtue of Yoga.

Yoga is a multidisciplinary art consisting of exercises with low intensity, techniques of breathing control, meditation, mindfulness and relaxation.[23] This could be addressed as mind–body medicine, which would be beneficial in improving muscle strength and endurance, postural stability and balance. Yoga also reduces fatigue, anxiety, depression and the risk of falls. Physical, mental, social and spiritual wellbeing would be promoted with aid of Yoga.[24] Positive immunomodulatory effect of Yoga is evidence based and could be an important factor responsible to reduce the chances of infection in respiratory tract.[25] Effect of yoga interventions in improving health-related quality-of-life and mental well-being was shown among elderly people (aged 60 years or above) in a systematic review of randomized controlled trials.[26] Yoga practice, a mind–body medicine is a least economic resource needed and easy-to-learn and practice intervention among elderly could be utilized as an ameliorating tool. Elderly COVID 19 patients could be potential candidates to obtain benefits from practicing Yoga. It is our duty to motivate elderly people to practice Yoga to combat against COVID 19 and related morbidity and mortality. 'Long COVID' related autonomic dysfunction is extremely crucial in developing different atrocities.[27] Autonomic neuropathy increases chance of sudden cardiac death where risk is aggravated by concomitant diabetes or increased age.[28] Practice of Yoga can address dysautonomia and could be beneficial in this regard too. There are evidences which suggest beneficial role of specific mantra chanting like Gayatri mantra to improve anxiety states. It is important to explore ancient Vedic teachings and their applications with Yoga to maximize benefits received.[29] Anxiety related factors potentiate complications of COVID 19 and which need special considerations in geriatric subjects.

Role of Yoga in cardiovascular disease, neuropsychiatry, respiratory, inflammatory disease, and metabolic disease is well established. There are a few studies suggesting its beneficial effects in infective disorders like HIV, Tuberculosis. COVID 19 involving spectrum of cardio-vascular-metabolic axis, neuro-behavioral, inflammatory, and respiratory health of human body requires an integrated approach like Yoga on top of conventional pharmacotherapy. Yoga means adding up. Adding multiple "I" gifts us "We". Yoga is a way of physical, mental, social and spiritual healthy living which erases illness and brings wellness. Medical scientists need to involve in more evidence generation to understand this important treasure of humanity.

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End of Life Care

Garima Handa

Dying is a definitive terminal event in the life cycle all living beings. The place; time; and manner of dying is individual in nature. Having stated that, it is desirable that the final days of life should be simple, comfortable, and spent with least possible pain. The greying world due to increasing expectancy of life has resulted in a large pool of elderly people. In India, the present projected numbers are around 10% of the total population.[1] A large proportion of these elderly are burdened with life limiting conditions and require palliative care towards end of life. The availability and accessibility of palliative care is sub-optimal with two-thirds of patients who die needing palliative care, with many such patients spending their last hours of life in the Intensive care unit instead. India ranks a poor 67 out of 80 countries[2] in the Quality of Death Index where quality of dying and death is described as, "the degree to which a person's preferences for dying and the moment of death agree with observations of how the person actually died, as reported by others".[3]

The elderly usually faces an increasing burden of disease as their age advances with few exceptions to this dictum. They often go through their senior years with one or more chronic morbidity interspersed with acute episodes and often require a lot of care for days, weeks, and even months before death. This is broadly 'End of Life' care and is described as support for people in their last month's / years of life enabling them to live as well as possible until death; and to die with dignity. The expression describes the medical care and support given during the time surrounding death. Such care does not happen only in the moments before the terminal event. It includes physical, emotional, social, and spiritual support for elderly and their families. The goal is to control symptoms, including pain, so the elderly can be as comfortable as possible.[4] It may include palliative care for the terminally ill/elderly and for their families by an organised health service; supportive care; and hospice care.

The focus of care given is comfort centric and customised to patient preference and needs; it is given in a comfortable environment in discussion with the patient and family; and takes precedence over other dimensions of care. For such care the home environment is preferred to the hospital setting where the focus is primarily on treatment.

'End of Life' care should be available to all irrespective of caste; creed; age; cultural background etc. Since it focusses on physical, emotional, social, and spiritual support for elderly and their families, making 'End of Life' plans helps lower the stress both for the individual and the family. Chronic life limiting conditions for which an elderly can receive end of life and palliative care include, but are not limited to:

- Cancer
- Heart and lung diseases
- Motor neurone disease and multiple sclerosis
- Alzheimer's disease and dementia
- Renal disease
- Stroke and other neurological conditions
- Other life-limiting illnesses.

The moot question which arises is, 'How to establish that the patient requires 'End of Life Care' taking into consideration all relevant clinical; ethical and legal issues? Guidelines for implementation of 'End of Life Care' developed by panel of experts from All India Institute of Medical Sciences (AIIMS), New Delhi, gives an insight into the issue. The process is basically divided into;[5]

1. Establishment of "Futility of further management" by the physicians – It should be recognized initially by primary physicians based on some general as well as disease specific criteria. The General criteria could be (i) Life expectancy expected to be in days to weeks; (ii) Any condition, where clinicians predict a very low chance of meaningful survival and purposeful life; (iii) post-

Consultant Geriatrician & Treasurer, GSI

cardiac arrest status with poor neurological outcomes; (iv) Brain dead patients, who are not suitable for organ donation. The Specific Criteria for futility of further management are decided by the team of clinicians of the concerned speciality considering the disease specific details. Once the futility of further management is identified by the primary treating physician, it must be validated by another physician of the same specialty, but not directly involved with the care of the patient. The consensus amongst physicians once established should be documented; and referral made to palliative services.

2. Consensus among all the caregivers on "futility of further management" and initiation of best supportive care pathway – The guidelines list four basic steps to be followed for reaching a consensus:
   a. Assess the mental competence of the patient for the ability to understand, appreciate, reasoning and expression of choices to take an informed decision. In case the patient is not mentally competent to give a valid informed consent, a surrogate decision maker should be identified.
   b. Identify the responsible Surrogate decision makers. They usually are the patient's family who make the decision in consultation with the treating team. If there are no documented surrogate decision makers, the hierarchy is (i) Spouse/de-facto spouse/partner with whom the patient has a relationship in the nature of marriage or a friend of long standing who regularly attends to the patient in the hospital; (ii) Available Adult Sons & Daughters; (iii) Available Parents; (iv) Available Adult Siblings; (v) Any other lineal ascendants or descendants of the patient who are present in the hospital and regularly attend to the patient.
   c. Proper communication to disclose the "Futility of Further management" and options for best supportive care - The primary clinician along with the palliative care physician and nursing officer should communicate to the patient and/or all concerned family members together in a meeting. The communication should take place in a language, with which they are comfortable. The communicating team must introduce themselves to all the family members present in the meeting. Communication should include explanation related to the terminal nature of illness emphasising (i) Short life expectancy; (ii) Burden versus benefit of further aggressive management; (iii) Option of end of life care as an alternative; (iv) Change of goals of treatment from cure to care; (v) Symptoms expected in last few days or hours and their comfort measuring strategies; (vi) Clarification of any myths or misunderstanding regarding illness and treatment; (vii) Recheck and ensure the understanding of prognosis and process of EOLC among all the caregivers. At the end of the 'Communication' meeting, the relevant checklist should be completed.
   d. Documentation - If the patient is mentally competent to take an informed decision, his/her wishes for withholding life sustaining support should be recorded and signed. If not, a written disclosure of futility of further treatment and withholding or non-escalation of life sustaining treatment is to be obtained once consensus amongst all family members is established,
3. Initiation of End-of-Life Care (EOLC) pathway by the palliative team after ensuring that listed pre-requisites in form of a checklist have been met. This is after consensus has been established amongst caregivers and treating team.
4. Symptom management and on-going supportive care till death with daily assessment of patient for holistic palliative needs, e.g. psychological, spiritual along with symptoms management at the end of life (e.g., pain, breathlessness, delirium, vomiting). Everyday supportive care plan/ treatments given should be documented for all in-hospital EOLC and any change in plan (Care to Cure) must be documented. For patients not on any life sustaining support, patient / surrogate decision makers may be given option for home based / hospice-based care.

The basic goals for end-of-life care are (i) controlling pain; (ii) prevention/management of complications; (iii) maintaining quality of life to the extent possible, including spiritual and psychological aspects. Common signs that occur towards end of life and their management are included in Table 1,[6]

The elderly during end of life requires medications to allay one or more symptoms/signs. Depending upon the requirement, the method of delivery could be (i) oral (liquids); (ii) Sub cutaneous; (iii) Transdermal; (iv) Cutaneous; (iv) Inhalation; (v) Rectal.

Recognizing the need of 'End of life care', the Government of India has taken several initiatives for promoting the concept and its introduction in the public health system. It launched National Program for Palliative Care in 2012. The objectives of the program are as under;

a. Improve the capacity to provide palliative care service delivery within government health programs such as the

Table 1: Common signs that occur towards end of life and their management include		
Signs / Symptoms	**Caused by**	**Management measures**
1.Pain	Disease process per-se	Pain medications supported by non-pharmacological measures (music etc.)
2. Nausea / Vomiting	Multiple causes	Anti-emetics relevant to overall patient management; small meals
3. Constipation	Sluggish peristalsis; reduced dietary fibre and fluid intake	Dietary changes; drugs
4. Drowsiness; Sleep Changes	Decreased physical activity; Slowing metabolism; Reduced oxygen to brain	Make them comfortable; Let them sleep; Sit quietly; Hold hands
5. Withdrawal from loved ones	Decreased cerebral oxygen supply, mental preparation for dying	Make them comfortable; respect their needs
6. Cold extremities	Decreased circulation to extremities	Keep warm and comfortable
7. Confusion/Anxiety/ restlessness	In part by slowing metabolism; reduced oxygen saturation; fear of dying	Reassure and keep comfortable; massage limbs; hold hands
8. Incontinence	Autonomic; Relaxation of muscles in pelvic area	Take expert advice; Keep clean and comfortable
9. Death Rattle	Build-up of secretions/fluid in airway/lungs	Elevate head end, Manage pharmacologically
10. Decreased food, fluid intake, urine output	Organ failure; Slowing metabolism; Decreased requirement; Impaired utilization.	Reassure and make comfortable; Do not force feed.
11. Change in breathing / breathlessness	Reducing circulation to organs; Metabolic changes.	Elevating head; Turning on their side; deep-breathing exercises, relaxation techniques, oxygen, and medications
12. Fever	Infection. Multi-organ failure	Cold sponging; Specialist advice

National Program for Prevention and Control of Cancer, Cardiovascular Disease, Diabetes, and Stroke; National Program for Health Care of the Elderly; the National AIDS Control Program; and the National Rural Health Mission.

b. Refine the legal and regulatory systems and support implementation to ensure access and availability of Opioids for medical and scientific use while maintaining measure for preventing diversion and misuse

c. Encourage attitudinal shifts amongst healthcare professionals by strengthening and incorporating principles of long-term care and palliative care into the educational curricula (of medical, nursing, pharmacy and social work courses).

d. Promote behaviour change in the community through increasing public awareness and improved skills and knowledge regarding pain relief and palliative care leading to community owned initiatives supporting health care system.

e. Develop national standards for palliative care services and continuously evolve the design and implementation of the National program to ensure progress towards the vision of the program

It is a centrally sponsored scheme wherein on the basis of a model PIP (Guidelines), the states/UTs may prepare their proposals related with Palliative Care and incorporate them in their respective PIPs to seek financial support under NHM.[7]

Continuing in the right direction, palliative care finds a place in the National Health Policy announced in 2017.[8] Further, palliative care has been formally introduced in the undergraduate (MBBS) medical curriculum from August 2019 under the competency medical education (CBME) and the Attitude, Ethics, and Communication Module (AETCOM). The new program is designed to create an "Indian Medical Graduate" (IMG) having requisite knowledge, skills, attitudes, values, and responsiveness, so that he/ she may function appropriately and effectively as a doctor of the first contact of the community and be globally relevant. The stress on palliative care and its importance begins from defining the role that the IMG is expected to play in the society as a clinician, i.e. understand and provide preventive, promotive, curative, palliative, and holistic care with compassion; to be competent in pain and distress alleviation, rehabilitation and palliation. Palliative care competency framework has been skilfully woven into the CBME it under various subject specialties as well as within

AETCOM.[9] MD courses are available in palliative medicine at 05 medical colleges, 04 of which are in government domain.[10] Though the developments are in the right direction, a lot need to be done to address the unmet need or 'End of Life care' in the community.

There is also a need to understand who can be care givers, what they want and what they need from the society at large. The way forward would include organising a robust format for 'End of Life Care', creating an awareness in the general population of this chapter in every individual's life. Awareness creation can be spearheaded by organisations, groups, societies by reaching out to the general public by Behaviour Change Communication (BCC) campaigns at social platforms, both formal and informal; print and social media. Concurrently, parallel to creating awareness, and in line with steps taken by the Government, a resource /workforce committed for End of Life Care can also be shaped productively, with NGOs/ societies taking the initiative to supplement Government efforts for creating a resource pool of care takers (workers of health & social sectors / school pass-outs with social orientation / faith healers etc.) in the rural and urban sector. It is worthwhile to remember that rural population still has a socio-cultural tendency for elderly care but the urban population needs it yesterday.

To conclude, End of Life Care is a supportive care, where the focus of care is patient centric rather than disease centric. The final days of life should be simple, comfortable, and spent in the least possible pain. The holistic care, including psychological and spiritual care is delivered by a team of primary care physicians, palliative care team (doctors, nurses, allied health professionals and spiritual care workers) and the family / extended family of the elder. It could be delivered in a hospital/hospice/community settings/home of the elder depending on the choice and need of the patient. A broad check list for 'End of Life care' can be as under;

a) Treat the elderly compassionately
b) Listen to them
c) Communicate clearly and sensitively
d) Identify and meet the communication needs of each individual
e) Acknowledge pain and distress and take action
f) Recognise when someone may be entering the last few days and hours of life
g) Involve people in decisions about their care and respect their wishes, keeping the person who is reaching the end of their life and those important to them up to date with any changes in condition
h) Document a summary of conversations and decisions
I) Seek further advice if needed
j) Look after yourself and your colleagues and seek support if you need.

Although challenging and emotionally demanding, end of life care can be very rewarding when supported by the right skills, knowledge and attitude.

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PRACTICAL TIPS

Prevention of Bedsores in the Elderly

Vigneshwaran S*, Ambali AP**, Mudassir Indikar***

Pressure ulcer is a matter of concern for caregivers and medical personnel. Pressure ulcer has been defined as an area of unrelieved pressure, usually over a bony prominence leading to ischemia, cell death and tissue destruction. It is a common cause of Mortality in bedridden patients.

Do's

- Make a gentle lift to move the patient from bed.
- Frequent changing of patient's position in bed is advised.
- Motivate the patient to move every 2nd hourly.
- Use of trapeze bars for self-movement of patient in bed.
- Pay special attention to skin areas with little fat padding, such as bony prominences (ankle, elbow) which are more prone for developing pressure ulcers.
- Use of pressure relief devices such as pillows, foam cushions, alternating pressure mattresses, air fluidised beds, gel heel protectors is recommended.
- Put patient on stool and urine voiding schedule.
- Routine check & change of diapers have to be practised in hospital for bed-ridden patients.
- Check bedsheets for sweat & urine regularly.
- Talcum powder application on patient's skin to prevent from getting wet from sweat.
- Application of lubricant like coconut oil are advised to moisturize dry skin.
- Always keep the bed sheets clean of food debris & crumbs.
- Make sure the patient is not lying over chest lead wires, or I.V drip set.
- Inspect for sacrum daily.
- Daily changing of wound dressing is advised in case of patient presenting already with bedsore.
- Place water filled gloves below bony prominence areas.
- Use breathable limb restraints to restrict altered behaviour of elderly patients in emergency care.

Don't's

- Make the elderly to lie on hard surfaces, floor mats.
- Drag the patient while propping up in bed.
- Drag the bedsheets while shifting the patient from bed to trolley.
- Massage of pressure areas are no longer recommended.
- Let the diaper in patient until it becomes heavy.
- Spill the food while feeding the patient in bed.
- Tie clothes over limbs to restrict the patient.
- Stick plasters over the skin of elderly patient.
- Use rough fabric while giving towel bathing to patient.
- Let the elderly wear crepe bandage or varicose shocks for long time in a day.

*Postgraduate Student, ** Professor, ***Assistant Professor, Department of Geriatric Medicine, BLDE DU, Shri B M Patil Medical College Hospital and Research Centre, Vijayapura -3. Karnataka

Certificate Course in Geriatric Medicine & Gerontology Version II

The second online certificate course on Geriatrics & Gerontology was conducted from 01st February 2022 to 06th May 2022. Eighty one delegates were registered for the same. An online exam was conducted & the successful candidates were allotted centres for their practical training.

Certificate Course In

GERIATRIC MEDICINE & GERONTOLOGY

Version-II

Organized

Jointly By

Geriatric Society of India® and Khaja Bandanawaz University

1st February 2022 to 6th May 2022

Every Friday & Saturday 08:00 PM to 09:30 PM

Mode of Learning : Digital/Handbooks

E-Course *through* Zoom Sessions

Two interactive sessions in a Week (Friday & Saturday)

Each session of One Hour Thirty Minutes

Assessment by MCQ's

Certificate presentation in

National Conference of Geriatric Society of India

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Dr. M. V. Jali
Dr. Prabha Adhikari

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Dr. O. P. Sharma

Editors

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Dr. S. Ramanathan Iyer
Dr. Sandeep Tamane
Dr. Vivek Handa
Dr. Rakesh Gupta

Online examination was conducted & successful candidates were sent for one day practical training at the following centres.
The following centres imparted one day practical training as part of the above course

Name of Trainer	Centre Name
Dr. Prabha Adhikari	Yenepoya Specialty Hospital
Dr. Pratibha Pereira	JSS Hospital AHER
Dr. Pradnya Diggikar /Dr. Shubhangi Kanitkar	Dr. D. Y. Patil Medical College Hospital & Research Centre
Dr. Arunanshu Talukdar	Medical College
Dr. Anita Basavaraj	Government Medical College
Dr. Purna Chandra Dash	SCB Medical College & Hospital
Dr. M. V. Jali	KLES Dr Prabhakar Kore Hospital & MRC

The candidates who cleared the exam successfully & attended the practical training will be awarded certificates during GSICON 2022 on 03rd December 2022 at Kolkata.

News from Kolhapur

World Sight Day

10th June, being World Sight Day was celebrated on Sunday 12th June at KMA House by GSI, IMA Kolhapur branch and Ophthalmic Society of Kolhapur.

85 people attended the public awareness program. Dry eye screening/testing was carried out with the help of Sun-Milmet and Ajanta Pharma. Members of Ophthalmic Society namely Dr. Mrs. Pooja Sasurkar, Dr. Mrs. Asmita Patane, Dr. Mahesh Dalvi and Dr. Sanjay Ghotane delivered talks on important clinical topics like Cataract, Eye donation, ARMD, Glaucoma respectively.

Elders' Abuse Prevention Day

15th June, being Elders' Abuse Prevention Day was observed on 15th June 2022. Advocate Mr. Santosh Shah emphasised on legal protection and benefits to the seniors. Mr. Sagar Kogale elaborated the use of National Helpline and its merits. Neuro Surgeon Dr. N. Y. Joshi presided over the function. He also inaugurated the free Geriatric OPD which was somewhat dormant during Covid period.

GSI Kolhapur president Dr. P. M. Chougule, GSI Kolhapur secretary Dr. Mahaveer Mithari, KMA president Dr. Mrs Geeta Pillai, KMA secretary Dr A. B. Patil were dignitaries on the dias. Master of ceremony was Dr. Mrs Manisha Bagwade.

News from Kohlapur

CME on Osteoporosis Plethora

21st August,being Senior Citizens' Day, GSI kolhapur chapter, clinched this golden opportunity to organise a CME for their esteemed members in association, as usual and always, with it's parent apex Body KMA (IMA kolhapur branch). The topic ofcourse was very much relevant and concerned with the health of elderly, ie. "Osteoporosis"..

The CME was conducted on Sunday 21st Aug.,between 9.30 am to 1.30 pm, at the Trimurti hall, KMA house, belbag, kolhapur.. Around 90 doctors attended it with keen interest..

GSI President Dr P M Chougule, Secretary Dr Mahaveer Mithari, KMA President (acting) Dr Amol Kodolikar, Secretary Dr AB Patil were dignitaries on the diice who inaugurated the event by "दीप-प्रज्वलन" (lightning the lamp)..

There were four eminent speakers, all belonging to kolhapur, comprising of two Ortho, one rheumatologist and one endocrinologist.

Dr Kiran Doshi, senior most Ortho surgeon talked about basic patho-physiology of the disease, dietary supplements, yoga and exercise to overcome it.

Dr Rishi Doshi, young Ortho surgeon narrated about the investigations, emphasising more on newer modalities like bone imaging, bone density, Dexascan for early diagnosis..

Dr Nikita Doshi,upcoming Endocrinologist, stressed on the endocrinal aspects of calcium and Vit D requirements and deficiencies, their proper doses,therapies in various disorders. She aptly supported her talk with couple of clinical cases..

Dr Waseem Kazi, flourishing Rheumatologist, correlated the use (misuse) of glucocorticoids for rheumatic conditions causing calcium/ D3 deficiency ,there on osteoporosis..He detailed about rational regimes of different drugs and their pharmacology etc..

Concluding Panel-Discussion and question answer session was also extensive as most of the members got their queries clarified .. Overall, the Speakers left no stone untouched pertaining to the topic "Osteoporosis" in a short span of 4 hours.

Dr. Mahaveer Mithari; Kolhapur.

News from Pimpri, Pune

Adult Immunization Program

An initiative of vaccinating the geriatric population was started by Dr. Pradnya Diggikar at Dr. Dy Patil Medical College, Hospital and Research Centre, Pimpri-Chinchwad, Pune.

On 17th February 2022, there was grand inauguration of the “ADULT IMMUNISATION” programme in medicine OPD on Thursday. Chief guests were Dr. Yash Raj Patil & Dr. Garcha. Dr. Pradnya Diggikar has delivered a lecture on immunization which was attended by around 80 patients.

Dr. Pradnya diggikar, Dr. Kranti, Dr.Prashant, Dr. Saranya, Dr. Nirali, Dr. Simran, Dr. Vaibhav, Dr. Archith & Dr. Sagarika took active participation in the event.

News from Vijayapura

Elders abuse Awareness Day

The Department of Medicine and Department of Geriatric Medicine in collaboration with API Vijayapura Branch, NPHCE & GSI Delhi organized an awareness talk on "Elder Abuse Awareness Day" on 23rd June 2022 in Dr. B C Roy Seminar Hall of the Department of Medicine. Dr S N Bentoor welcomed, Dr. S S Yarnal chaired the session & Dr. Sharan Badiger presided over the function.

Dr Anand P. Ambali delivered a lecture on Elder Abuse. He discussed case scenarios, and the role of physicians in identification, methods, types of abuse, and counselling for victims of Abuse. Dr Santhosh B T and Dr Sneha Mukherjee were moderators. The faculty from the Department of Respiratory Medicine, Pharmacology, and postgraduate students & 80 delegates attended the programme. Dr Mudassir Indikar proposed the vote of thanks.

National Doctors Day 2022

The Sashi Dham old age home at Vijayapura invited Dr. Anand P Ambali as chief guest for the programme to honor the occasion of National Doctors Day 2022. Dr. Ambali was honored for his services to the senior citizens over the last 15 years. The owners Mr. Amit & Mrs Aishwarya honored Dr Ambali.

He addressed the gathering and mentioned that an old age home should no more be an ill dignified life, instead it should be used as a home for freedom. He also ensured medical assistance for the older people as and when required. Dr Ambali donated two books on Health issues of old age to the library of the home. Mrs Bhagirathi Shinde, and other office-bearers of the old age home were present.

Congratulations Dr. Ambali

for Guest faculty in CME on Dementia on 23rd July 2022 in a webinar organized by DPU, Pune

Felicitate the Posthumous Body Donors

The Department of Geriatric Medicine and The Karnataka Body Donation Society, Department of Anatomy jointly organized a program to felicitate the Posthumous body donors on 30th July 2022 in Academic Council Hall between 10 AM to 10.30 AM.

The Chief guest was Dr. Prabha Adhikari & Dr. Anand P Ambali, Vice President of the Geriatric Society of India welcomed the gathering and mentioned that the older people who have pledged their body are blessed and highly spiritual.

Dr. Prabha Adhikari in her address said that she was happy to know that the people who are donating their bodies for research are happily donating and she also shared her personal experience when her father expired, it was her mother who reminded her that the father's eyes should be donated. She also said that a similar programme will be launched in Mangalore.

Dr. S V Patil, Vice Principal announced that the BLDE University has decided to provide Free Comprehensive health check-ups for all the posthumous donors registered from the year 2021 January, once a year.

Dr. Arun C. Inamdar Pro Vice Chancellor said that Body donation is the greatest Donation of all. He narrated the story of Danaveer Karna and said a similar example is laid down by the donors present here. He also suggested health check-ups should be carried out on the Birthday of respective donors. Thirteen people had pledged for body donation and were felicitated.

Shri Sangappa Shivangi, shared his experience with spirituality and thanked the BLDE association for making such arrangements for the posthumous body donors.

Mr. Basavraj Ukanal and Smt Sulochana were also honored for assisting the donors.

Mr. R P Mali was master of ceremony and Dr. Ravi Bulgouda, Chairman of Karnataka Body donation proposed

News from Vijayapura

The Department of Geriatric Medicine, along with SARS of BLDE DU, API Vijayapura Branch, & GSI Delhi jointly organized offline Guest lecture by Dr. Sonjoy Mukerjee, Ph.D who is Senior staff scientist, Thermo Fisher Scientific, Boston, USA , Global Technical Leader-Vaccines and Research Scientist University of California on 31st July 2022 in Medical Education Hall.

The topic for discussion was "Growing Diversity of Biological molecules under development to meet health care needs" in which he explained in detail Biologics, Gene Therapy, production of Mono Clonal Antibodies, the role of Bio Technology in treating diseases, the production process of vaccines and his role in the formation of Hepatitis B Vaccine in India.

Dr. Kusal K. Das, Distinguished Chair Professor (Vascular Physiology), BLDE DU, Vijayapura chaired the session and engaged the audience with fruitful discussion. Dr. A P Ambali welcomed the gathering, Dr. Santhosh B T introduced the guest faculty, and Dr. Vigneshwaran proposed a vote of thanks.

Polypharmacy in the Elderly

The department of Geriatric Medicine, along with API Vijayapura Branch, & GSI Delhi jointly organized an offline Guest lecture by Dr. Prabha Adhikari M R, who is Professor and HoD of the Department of Geriatric Medicine, Yenepoya University, Mangalore and Past President of Geriatric Society of India, Delhi. The guest lecture was organized on 30th July 2022 in Dr. B C Roy Seminar Hall.

The topic for discussion was "Polypharmacy in the elderly". Madam elaborated definition, identification of polypharmacy, types of polypharmacy as appropriate and inappropriate polypharmacy, and carious scales like BEERS criteria, STOPP and START Criteria in her presentation.

Dr. Rajeev Malipatil, HoD Geriatric Medicine and Dr. S M Biradar, Professor of Pharma D, BLDEA's SSM College of Pharmacy & RC, Vijayapura chaired the session and engaged the audience with fruitful discussion.

Dr. A P Ambali welcomed the gathering, Dr.Sandeep Kumar introduced the guest faculty and Chairpersons, Dr. Vijayalaxmi presented mementos to the guest and Dr. Abrar Ul Huq proposed a vote of thanks.

Health Awareness Talk for Senior Citizen

The Faulty of Department of Geriatric Medicine was invited to address the senior citizens of Padmashri Kaka karkhanis Senior Citizen forum on 10th April 2022. The topic of discussion was "Health issues in senior citizen – protection and prevention".

Chairman of the forum Shri Karadi welcomed the gathering. Dr Anand P Ambali addressed the senior citizens on various health issues, atypical presentations of the diseases, red flag signs to consult a physician, importance of regular health check-up, services provided by BLDE DU and prevention of various diseases in elderly.

The services of Demetia Clinic, Immunization Clinic, Library for Senior citizen were emphasized.

Shri M M Bidari Secretary presided and gave his presidential remarks.

News from Kolkata

GSI West Bengal institute of training & research (GWITER) of Geriatric Society of India is organizing programs on manpower developments.

Kindly pay Rs.1,500/- (Rupees One thousand five hundred) online and mail payment particulars to our email address gwiter2022@gmail.com.

Next option in the enrollment submenu is registration, click on it and register yourself. Then you can log in as student and you can browse video.

Once payment gateway starts functioning then one has to use payment submenu after student logging in and you will get confirmation SMS after payment.

Wish happy journey with us. Regards- Team GWITER.

About The Institute (GWITER)

GSI WB Institute for Training, Education and Research (GWITER)

GSI WB Institute for Training, Education and Research (GWITER) is established by a resolution of the Central Executive Committee / GB of Geriatric Society of India West Bengal Branch on 27.03.22 at GB meeting of the branch to fulfil the object of the branch (Branch Reg.No. S0007580 of 2019-20) with the following objectives-

Objectives :

- ✓ To make trained manpower in the area of Geriatric Care (presently in Virtual mode)
- ✓ To ensure uniformity and continuity on need based curriculum, for doctors, paramedics and Geriatric Social Worker.
- ✓ The institute expects all the Geriatric Physicians to fully involve themselves in the various programmes and raise the status and prestige of the now recognized specialty of Geriatric Practice.
- ✓ To promote research in the field of Geriatrics.
- ✓ To keep database on Geriatric Medicine.
- ✓ To formulate guidelines on different Geriatric Issues.
- ✓ To confer upon responsibility to run related programme to chapters on being applied for.

Name of the Institute :

GSI WB Institute for Training, Education and Research (GWITER).

Head Quarter: Dyuti Elderly Care Centre, 44,Milan Pally, Ground Floor, Airport 2nd Gate, DUMDUM, Kolkata-700079.

Contents of the GSW training Programme (Online pre-recorded Videos) Duration -06 (SIX) months.

Messages(1-4) :

1) Dr.P.S.Shankar, Patron, Geriatric Society of India
2) Dr.V.K.Arora, Patron, Geriatric Society of India
3) Dr.O.P.Sharma General Secretry, Geriatric Society of India
4) Dr.Chinmoy Kumar Maity, Chairman GSI West Bengal Branch & GWITER.
5) Introduction to the training - Dr. Mainak Gupta, Convenor, Gwiter.
6) Gerontology - Dr. Kaushik Ranjan Das
7) How Geriatric Medicine is Different? - Dr. Kaushik Ranjan Das
8) Age related changes in the body, Components of Geriatrics Hidden diseases, Common diseases, - Dr. Krishnanjan Chakraborty.
9) Geriatrics and other systems of medicines prevailing in India - Dr.P.S.Shankar
10) Human Anatomy part I. (2 lectures) - Dr.Mainak Gupta
11) Human Anatomy Part II - Dr. Mainak Gupta
12) Human Physiology. - Dr. Debopriyo Bakshi
13) History Taking - Dr.Anand P Ambali
14) Geriatric Assessment - Dr.Aniruddha De
15) Imaging in Elderly & Common Laboratory Values- Dr.Asoke Das
16) Diagnostic -A New Dimension for GSW Dr.Mohit Sharma
17) Practical demonstration Videos, a,b,c,d,- Dr. Kaushik Ranjan Das & Dr.Dhires Kumar Chowdhury.
18) Preventive aspects of diseases in elderly- Dr.Rahul Bhattacharyya

19) Healthy Life 5tyle for healthy aging including Exercises in Elderly, Meditation and Vaccination- Dr.Kaushik Ranjan Das

20) Spirituality and Yoga- Pandiamani B K

21) Nutrition in Elderly & Diet in special situations- Dr.Arijit Das

22) Assisting Devices : Dr.Vivek Handa

23) Infections :

i. Respiratory tract infections,

ii. UTI ,

iii. Diarrhoea,

iv. Dysentery,

v. Skin infection - Dr.Chinmoy Kumar Maity

24) Dyspepsia - Dr.Soumik Ghosh

25) Constipation- Dr. Soumik Ghosh

26) Hypertension - Dr. O.P.Sharma

27) Ischaemic Heart Disease And Cardiac Arrhythmia - Dr.A.K.Singh

28) Cerebrovascular Accident- Dr. Kausik Majumdar

29) COPD / Asthma - Dr. Arunansu Talukdar

30) Dementia - Dr.Sachin Desai

31) Movement Disorders - Dr.Krishnendu Roy

32) Musculoskeletal Disorder - Dr.Suddhasatwya Chatterjee

33) Frailty Syndrome with Care Givers Role - Dr.Vasha Jayar Reddy

34) Depression and other mental disorders including caregivers role - Dr. Bappaditya Chowdhury

35) Diabetes in Elderly -Caregivers Role - Dr. J. K. Sharma

36) Thyroid Disorders In Elderly- Dr. Pranjal Kumar Dutta

37) Falls & Pressure Sore - Dr.Taruni Ngangbam

38) Incontinence - Dr. Sandeep P Tamane

39) Common eye problems - Dr.Pradnya Mukund Diggikar

40) ENT Problems in Elderly - Dr.Ranjita Bhattacharjee

41) Oro-Dental problems in Elderly - Dr.Smita Athavale

42) Women's (Elderly) Health - Dr. Sharmistha Chatterjee

43) Environmental and Occupational Diseases - Dr. Sudhir Kumar

44) Neurological Emergencies in Elderly - Dr.Jayanta Sharma

45) Respiratory distress & Chest pain in Elderly Dr.Purna Chandra Dash

46) Abdominal pain & Urinary Retention in Elderly Dr.Samudra Gooptu.

47) Advanced Alzheimer's Disease - Dr.Prabha Adhikari

48) Advanced Parkinsonism: Dr.Prabha Adhikari

49) End Stage Renal Disease. Dr.Shankha Shubhra Sen

50) Advanced Cirrhosis Of Liver - Dr.H.S.Pathak

51) Heart Failure - Dr.Jyotirmoy Pal

52) End of Life Care - Dr.Garima Handa

53) Social issues in Geriatric care - Dr. Kaushik Ranjan Das

54) Elderly and In built environment - Dr. Kaushik Ranjan Das

55) Geriatric Social Worker plus Geriatric Nurses - Dr. Kaushik Ranjan Das

56) Nursing skill in Elderly Care - Dr.Prabha Adhikari

57) Communication Skill with elderly- Dr. Priyadarshini Sharma

58) Care Giver issues - Dr. Kaushik Ranjan Das

59) Geriatric Care & Family Bonding - Dr. Kaushik Ranjan Das

60) Elderly Abuse - Dr. Santosh Kumar Swain

61) Laws, constitution and other provisions - Dr. Soumi Chakraborty

62) Pre-retirement Planning - Dr. (Col.) Pramod Kumar

63) Insurance and Mediclaim - Dr.Aniruddha De

64) WILL: Dr. Krishnanjan Chakraborty

65) Living Will: Dr. Aditi Choudhury

66) Home Health Care with emphasis on Caregivers Role - Dr.Dhiresh Kumar Chowdhury

67) Basic Care (Lifting, moving &first aid) - Dr. Ramana Rao GV

68) Important days in History of Geriatrics: Dr. Dhires Kumar Chowdhury

69) Care givers role-a non-medicos view- Mrs Shanti Sharma

Visits to Senior Citizens Home –
On the choice of Participants. Contact Sessions – On the choice of participants.
Final Assessment (online) Certification.

GLIMPSE:
Course Duration – 06 (six month).

Eligibility- Pan India participant 10+2 passed and above.

(Under exceptional cases educational qualification can be lowered) Medium of Study: English

Course Fee: 1500/= inclusive of a copy of "A guide for a Geriatric Social Worker (Caregiver), certificate and postal charges.

Course Module: GSI Approved Module and includes contact sessions as determined by the Institute. Invited Faculty: Pan India GSI Members and also Non Medicos.

For Enrollment, Please Visit Web Site :https://gwiter.in Team Gwiter.

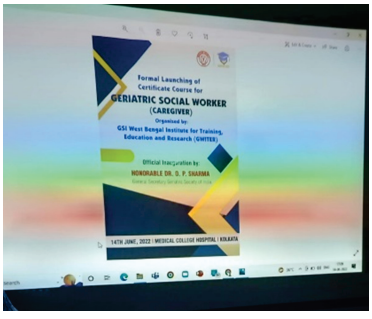
News from Kolkata

Matching technological advancement with needs of elderly in India

Dr. Aniruddha De, Eastern Zonal Coordinator of GSI and Treasurer GSI Eastern Zonal branch has joined as main speaker at a conclave of members (Biomedical Engineers) of Institute of Engineers India on 22.05.22 at IEI auditorium. Topic of discussion was Matching technological advancement with needs of elderly in India. Dr. Aniruddha discussed all pros and cons of the issue and urged upon them to procced with collaborative view with GSI. Biomedical Engineers have affirmed that they will extend their full technological support to GSI for betterment of senior citizens of the country and also stressed on exchange of views in coming days.

News from Kolkata

WEAAD 2022



Celebration of WEAAD 22 and Formal inauguration of online pre-recorded video training programme for geriatric social worker has been convened on 14.06.22 at 3pm at seminar hall of the department of Geriatric Medicine, Kolkata Medical college, being organized jointly by Geriatric Society of India West Bengal branch and Department of Geriatric Medicine, Kolkata Medical College. The meeting has been graced by Vice Chancellor, West Bengal University of Health sciences; Principal, Kolkata Medical College, Office bearers and members of GSI WB Branch, trainee of GSI certificate course version II, members of Pronam of Kolkata Police; members of NGO including help age India, CMIG & Banchbo and others. Key note address was been delivered by Dr. Kaushik Ranjan Das, President GSI, Dr. Arunansu Talukdar and Dr. Dhires Kumar Chowdhury have been instrumental in the celebration.

Formal inauguration of GSW training programme has been done virtually by General Secretary of GSI, National Professor Dr. O.P. Sharma .The programme has been attended by Dr. Asoke Das, Dr. Chinmoy Kumar Maity , Dr. Krishnanjan Chakraborty, Dr. Aniruddha De, Dr. Mainak Gupta, Dr. Jayanta Sharma, Dr. Bappaditya Chowdhury, Dr. Suddhasatwya Chatterjee, Dr. Sharmistha Chatterjee,Dr.Arunansu Talukdar, Dr. Rahul Bhattacharyya, Dr. Dhires Kumar Chowdhury and Dr. Kaushik Ranjan Das , Dr.Nimai Chandra Mondal.

Answers:
1. E 2. G 3. F 4. C 5.A 6. J 7. I 8. B 9.D 10. H

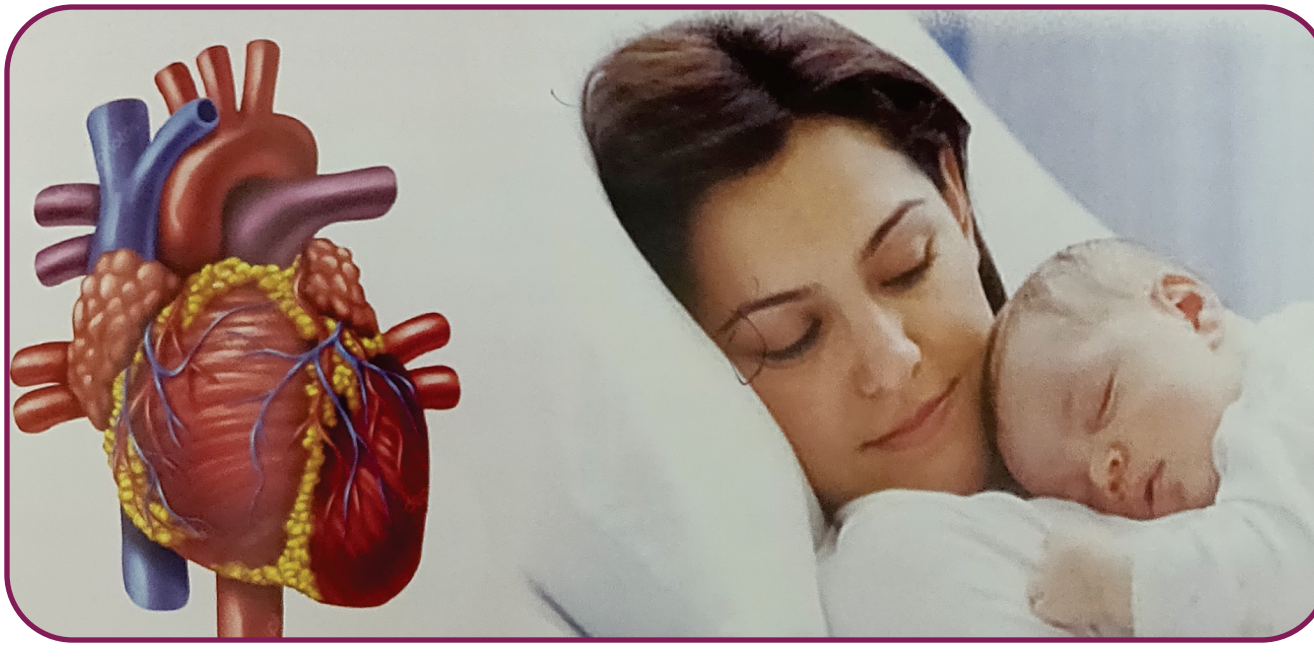
With Best Compliments From

Dr. Satish Gulati
M.D.F.I.C.P., F.I.A.M.S., F.G.S.I.
Consultant Physician & Geriatrician
Cell: +91-9812026168

Dr. (Mrs.) Rita Gulati
M.D., D.G.O., F.I.A.M.S.
Consultant Obstetrician & Gynaecologist
Cell: +91-9896342097

Dr. Dishant Gulati
M.B.B.S. M.D. (Medicine)
Consultant Physician
(Former Assistant Professor SGT Medical College, Budera (Gurgaon)
Cell:+ 91-8930198124

Ms. Divya Gulati
Computer & Administration In-Charge
Cell: +91-9996233397



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