IJGC

INDIAN JOURNAL OF GERIATRIC CARE

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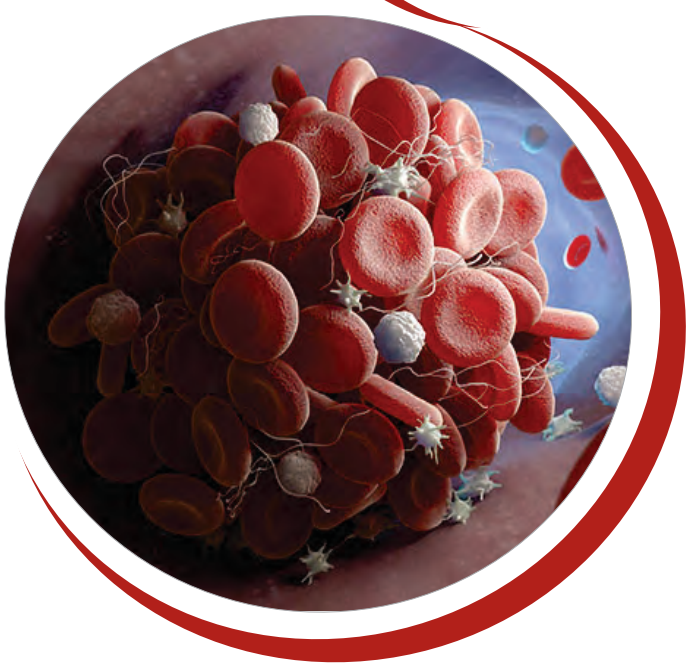

HIGHLIGHTS

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!!

Mid-Term Conference 2023

Geriatric Society of India®

29 – 30 April 2023

at

Scientific Convention Centre, Lucknow

Organizer

Dr. Kauser Usman

kauserusman87@gmail.com

Further details will be emailed soon

Editorial Board

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Editorial

Dr. Kaushik Ranjan Das
Guest Editor

Caregivers and Falls

INTRODUCTION

Falls in the elderly has been a common occurrence and leading cause of injury related death in the elderly worldwide. Falls impact morbidity and mortality, quality of life, productivity, both national and pocket expenditure and caregiver burden.

A caregiver (formal or informal) can help a person immediately after fall by direct assistance and also by training before an event by demonstrating the way of getting up and seeking help. A caregiver can do a mile by taking fall preventing measures either individually or as member of Geriatric team or as directed by appropriate person; thereby conferring older persons, better quality of life, preserving productivity , saving money etc, i.e healthy aging.

FALLS

Falls has been one of the prominent Geriatric Giants, that have multiple causation, chronic course, deprivation of independence and no simple cure.

A fall is defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level.[1]

About 28% to 35% of elderly aged 65 years and more fall each year, and the incidence of falls increases with age and frailty. Apart from physical injury, falls have a significant psychological and social impact on elderly, that also includes fear of falling, loss of confidence in their balance and activity restriction.[2]

CAUSES OF FALL[3] –

A. Intrinsic Causes

1. Neurological disorders

a) Impairment of cognition
b) Impairment of vision
c) Impairment of hearing
d) Postural instability
e) Peripheral neuropathy
f) Parkinsonism
g) Stroke

2. Cardiovascular disorders

a) Aortic stenosis
b) Syncope
c) Arrythmias

3. Musculoskeletal disorders

a) Osteoarthritis
b) Foot abnormalities
c) Muscle weakness

4. Drugs

a) Polypharmacy
b) Antidepressants
c) Sedatives/Hypnotics

d) Diuretics

e) Vasodilators

B. Extrinsic Causes

1. Ground surface

a) Uneven slippery

b) Loose carpets

c) Low lying objects

2. Furniture

a) Low lying furniture

b) Chairs without arm support

3. Lighting

a) Poor lighting

b) Glare from lamps

4. Improper walking aids and foot wears

Fall Preventive measures

1. Management of environmental factors is crucial with attention to-

✓ Potential obstacles

✓ Slippery surfaces

✓ Trip risks within the house

✓ Improvement of lighting

✓ Elimination of ill-fitting or inappropriate footwear

✓ Inappropriate assistive devices

2. Medication choice and polypharmacy

✓ Attention to medications and polypharmacy can prevent elderly to fall

✓ Other strategies that may be helpful- "start low and go slow"

3. Diet and Exercise

✓ Well balanced diet and vitamin supplementation

✓ Over restriction of salts to be avoided

✓ Proper hydration

✓ Avoidance of hypoglycaemia

✓ Exercise – individually tailored programme for gait training, strengthening and balance

Other Fall prevention measures

✓ Make an appointment with doctor (medications, supplements, treatment of the health conditions, evaluation of strength and balance)

✓ Keep moving

✓ Wear sensible shoes

✓ Remove home hazards

✓ Proper lighting of living space

✓ Use assistive devices

✓ Family and social support

CAREGIVERS

Geriatric Caregivers (Geriatric Social Worker)

Definition: Caregivers are trained attendants who help patients in their daily activities such as bathing, dressing, eating, and maintaining personal hygiene etc.

Types of Caregivers are:

➢ Professional,

➢ Independent,

➢ Private,

➢ Informal

➢ Volunteer caregivers.

Activities of a Professional Caregiver (Geriatric Social Worker –GSW)

- ✓ Assessment of condition ,
- ✓ Determining place and type of treatment,
- ✓ If required, arranging geriatrician / physician for managing the condition ,
- ✓ Providing services following doctors' advice
- ✓ Working as a member of geriatric care team if so constituted .
- ✓ Will assist in transportation and attending health care facility with regular visit to the elderly if hospitalized ,
- ✓ Will make contact with next to kin of the elderly and discuss the matters to them including financial matters ;
- ✓ Will follow the direction of the concerned elderly if he/ she is in full sense .
- ✓ GSW will assist the elderly in purchasing medicines etc .and assist in taking medicines according to physicians advise.
- ✓ He/ she will provide assurance and will try to boost up his/her mental strength and also will try to inform his patient about recovery of their illness.
- ✓ GSW will site references of recovery of some similar patients may be known or unknown to the concerned elderly.
- ✓ Will inform elderly about care facilities including old age homes .

Caregivers concern for elderly people falling at home[4]

Falls among older people at home generally increase a carer's burden. This is particularly the case as care needs increase and there is continued concern about the potential for ongoing falls. As people age, they experience concomitant physical (and cognitive) decline, which increases their risk of falls and need for increased fall vigilance. Furthermore, carers are a trusted source of information, and well placed to negotiate, engage and initiate strategies to prevent the older person from falling at home. A randomised controlled trial found that carers who engaged in fall prevention programmes had significant improvement in fall risk awareness and fall prevention strategies for older adults with cancer. Another study on the efficacy of a home-based, carer-enhanced exercise programme found significant improvement in balance, fall concern and physical activity among older people living with dementia.

How Caregivers (GSW) can help an elderly regarding fall

1. Assessment

By history including functionality and independence , medical history, medication use, nutritional status, assessment of fall risk and frailty status (by using simple tools),home environment and other related environment.

2. Plan of Action

a. Helping the victim in supporting him /her to prevent further injury and transferring them if needed or provide care at home.

b. Imparting training to individual ,how to get up from fall and seek help .

c. Proper Diet.

d. Appropriate Exercises : Flexibility, strength ,balance, endurance exercises.

e. Regular vision check

f. Making home environment elderly friendly

g. Managing medication properly

h. Suggesting mobility aids , foot wears etc.

i. Companionship – thereby helping elderly achieve a state of mental wellbeing.

j. Prohibiting abuse of drugs /alcohol.

k. Consultation with other members of geriatric care team.

l. Ensuring regular visit to doctor etc.

m. Training family caregivers

3. Follow up / review

4. Modification of activities as needed

5. Keeping record

CONCLUSION

From above stated affairs, it is clear that Caregiver's (GSW) role is extremely useful in helping an elderly after fall and also in preventing fall. Bottleneck is that, in India we have meagre trained caregiver and hence the problem of fall prevention appears difficult at this point of time. The need of the hour is to make trained Geriatric Caregiver in huge number. ASHA worker may be trained and could also be game changer. Let us work together at this end.

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RSSG: The Future of Community Based Geriatric Care

Shikhar Bajpai*, Krutika Bajpai**

The Indian elderly due to the absence of joint-family has become the victim of depression and "neglected ageing". Community based care can replace the absence of joint–family. This study has led to the foundation of a RSSG, which can be used as a foundation for future improvement of community based care.

Methodology: A Senior Citizen Group(RSSG) consisting of 10 senior citizens who were all residents of Lakhimpur was formed and they were made aware of- 1. Diseased vs Healthy ageing; 2. Nutrition; 3. Compliance to medications; 4. Available health schemes for elderly, 50 individuals were studied before and after interaction with the RSSG with the help of a questionnaire.

Results: Significant increase was found after interaction with RSSG - 1. 90% elderly were aware that their disease was not due to ageing. 2. 60% elderly thought they were malnourished. 3. 70% elderly were more compliant to regular medication intake.

4.70% elderly were aware of the health schemes available to them. 5. 70% elderly believed that their condition could not improve with treatment. Conclusion: This study showed that RSSG can actually have impact on creating awareness about disease and healthy ageing, compliance to medication and awareness of economic schemes. However, it did not have much impact on creating awareness for nutrition and openness to medical treatment.

Keywords: *RSSG (Retired Senior Citizen Group) , Neglected Ageing*

INTRODUCTION

- Communal efforts are better than individual efforts to move the wheel of time to future.
- The Indian elderly who have been forced into nuclear family system from the traditional joint family system has not only become the victim of loneliness and depression but also of "neglected ageing".
- Although several studies done in various regions of the world has implicated the importance of community based care but they have failed to provide a fool-proof plan for implementation.
- This study has lead to the foundation of a RSSG- a micro social group, which can be used as a corner-stone for future improvement of community based care.

AIMS & OBJECTIVES

Aim

- To study the future of community based strategic approach in Geriatric Care Awareness
- To formulate a plan of action to implement in future times as community based care for elderly

Objectives

- To make community based care available for elderly at home
- To make stratification in middle class community by creating a self – help group of individuals
- To give a plan of action to the group to implement for the rest of the community
- To study the impact of non medical & social approach for the care of elderly

MATERIALS AND METHODS

- A micro social group consisting of 10 senior citizens who were all residents of Lakhimpur Kheri was formed. This group of people were retired from various professions and all between the age of 60-70 years had attended monthly meetings making them aware of the importance of:

1. Diseased vs healthy ageing
2. Nutrition
3. Compliance to medications
4. Available health schemes for elderly

- 50 elderly individuals in Lakhimpur area were randomly selected who were not part of the above RSSG. It comprised of 25 male and 25 female elderly. These individuals were given a questionnaire and asked to fill it twice – Once before the exposure of one year (31st October 2021) to RSSG and second time (on 31st October 2022) after the completion of the year from contact with the RSSG.

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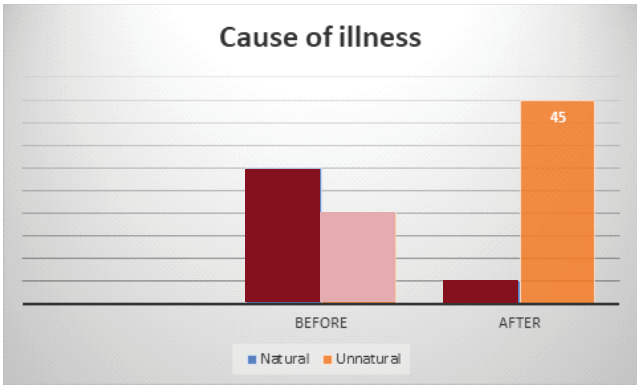

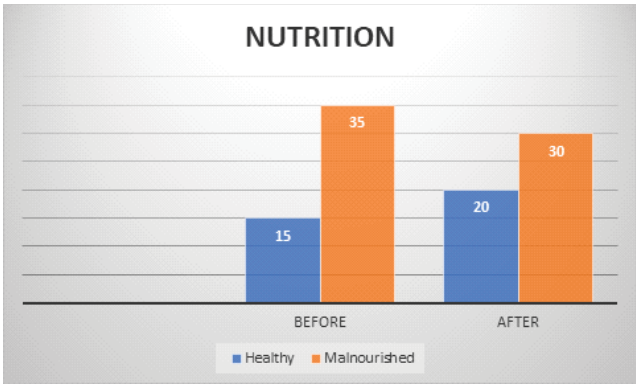

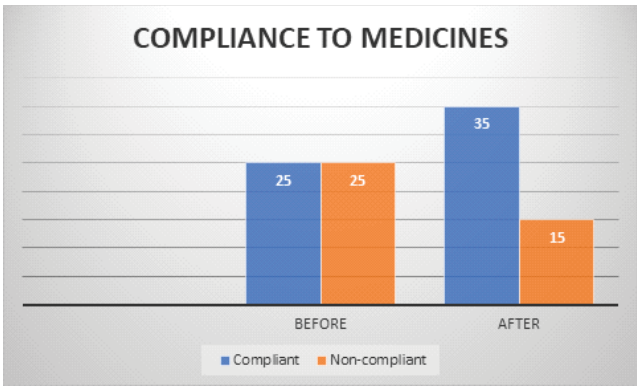

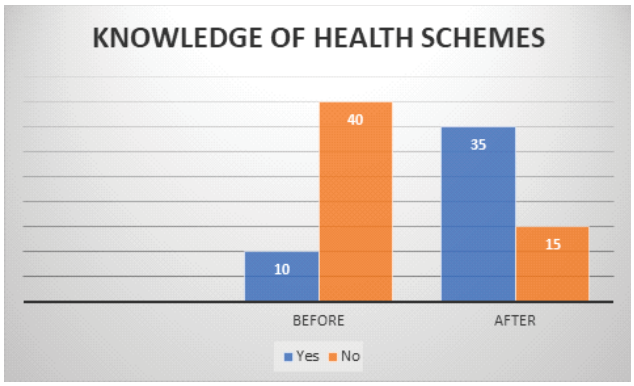

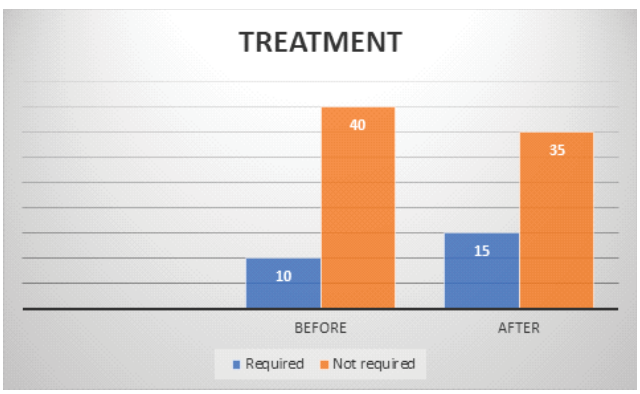

- The questionnaire comprised of following:
  Do u think you are ill? Yes/No
  Cause of your illness? Natural/Unnatural
  Is your diet nutritious? Yes/No
  Do you take your medicines regularly? Yes/No
  Are you aware of schemes for elderly? Yes/No
  Do you think you will be relieved with treatment? Yes/No

RESULTS

- **From the questionnaire before interaction with RSSG following features were obtained-**

1. 60% elderly thought that their health conditions are due to ageing and 40% thought it was due to disease conditions.
2. 30% elderly thought that their diet was nutritious and 70% thought that they were malnourished.
3. There was 50% compliance to taking medications regularly.
4. 20% elderly were aware of the government and private schemes available for their health care and 80% were unaware.
5. 20% elderly believed that they require treatment for their condition and 80% thought they do not require treatment.

- **From the questionnaire after interaction with RSSG following features were obtained-**

1. 10% elderly thought that their health conditions are due to ageing and 90% thought it was due to disease conditions.
2. 40% elderly thought that their diet was nutritious and 60% thought that they were malnourished.
3. 70% elderly were compliant to their medications while 30% were non compliant.
4. 70% elderly were aware of the government and private schemes available for their health care and 30% were unaware.

5. 30% elderly believed that they require treatment for their condition and 70% thought they do not require treatment.

CONCLUSION

- **This study showed that creating awareness amongst senior citizens by forming a micro social seniors group (RSSG) as a part of community based care had the following impacts-**

1. More people were aware that being sick is not a natural part of ageing process.
2. More people were getting compliant to medications and understood its importance.
3. More people were made aware of economic schemes available for them.
4. However it failed to have much impact when it came to creating awareness for nutrition and openness to receive medical treatment.

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Patient Satisfaction and Quality of Geriatric Medicine OPD in a Tertiary Care Hospital in Goa

Edwin Gomes*, Adishree Devendra Kenkre**, Vishal Khandeparkar***

INTRODUCTION

Geriatric population is a rapidly growing age bracket in India and globally. However, this segment of the society is not receiving its due share of health services despite facing a myriad of medical problems.[1] Earlier geriatric patients used to attend routine OPDs but specialised Geriatric OPDs have been started recently across various Medical Centres and Hospitals. It is very important to procure the input of patients regarding health services and their expectations from these services.[1]

According to the WHO, level of satisfaction is an important tool to measure patient healthcare.[2] There are many studies done in our country to evaluate patient satisfaction and all of them have emphasised on developing ways to satisfy the patient as the scenario has changed from the past.[2] The patients' perceived needs, his expectations and experience of health care all affect patient satisfaction.

There are many determinants of patient satisfaction which can either be provider related or patient related. The physician's proficiency and interpersonal communication skills, behaviour of hospital staff, access to care, basic facilities, and infrastructure are some important determinants.[3] Thus, the reason for laying great emphasis on patient satisfaction is that it is linked to improved compliance of doctor's instructions, timely care seeking by the patient, and greater comprehension and retention of the information provided by the health care provider–all ensuring a favourable health outcome.[3]

The opinion of the patient has an influence on the compliance of treatment and the continuity of the patient–physician relationship, as well as the final outcome of the treatment.[4] Information is provided not only about positive aspects of health care delivery system but also about the negative aspects which needs to be focused for further improvement of the service.[4]

OPD is the first point of contact with a patient and serves as the window to any health care services provided to the community. Ultimately the knowledge about quality of services in the Geriatric OPD will serve two purposes: identifying areas of improvement in quality of services so offered, and highlighting the need for corrective actions.[4] Geriatric Medicine OPDs follow sustained, intensive interdisciplinary process that begins with a comprehensive geriatric assessment of all that affect health of the patient. It is designed to maximize not only the physical but also the psychological and social functioning of high-risk older persons.[5]

As Department of Geriatric Medicine is newly created in the Institute of Goa Medical College and Hospital, Goa, and no satisfaction study has been done with respect to geriatric patients, we aim to evaluate the performance of outdoor services in the form of patient satisfaction and in turn assess the functioning of Geriatric Medicine OPD services which exists only in Goa Medical College on a regular basis.

NEED FOR THE STUDY

The Geriatric Medicine Department has been recently started in the Institute of Goa Medical College and Hospital, Goa and no previous studies have been done to assess the patient satisfaction and the Quality of the Geriatric Medicine OPD. The study will help us to assess the quality of services rendered at a tertiary care hospital with a view to improve them by identifying the gaps and bridging them. In addition, it will also help us to identify factors associated with perception of service quality and overall satisfaction of our patients.

REVIEW OF LITERATURE

Gopal K Ingle (2008): There is a need to highlight the medical and socio-economic problems that are being faced by the Geriatric population in India, and strategies for

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bringing about an improvement in their quality of life. At the tertiary care level, a provision of geriatric wards and separate OPDs to be provided. A multi-disciplinary team including a physician, psychologist, physiotherapist, dietician and nurses trained in geriatric medicine to be created.[6]

Lynne Morishita (1998): A randomised control trial to evaluate the high-risk older adults' satisfaction with outpatient geriatric evaluation and management (GEM). 522 patients with age 70 years and older were randomly assigned to receive either usual care or GEM for six months. The mean satisfaction scores of the recipients of GEM were 9% higher than those of the recipients of usual care.[5]

Pooja Goyal (2016): A hospital based; descriptive cross-sectional study was done in a tertiary care hospital in Faridabad using a pre-structured, pretested Performa. The assessment of client perception on quality of health services and overall satisfaction was done. The most important reasons for satisfaction were good doctor behaviour (51.7%), medicine availability (38.6%) and cleanliness (35.4%) in the hospital.[4]

Fatima Mukhtar (2013): A descriptive cross-sectional study was done in a tertiary care hospital of Lahore to determine the level of patient satisfaction towards OPD services with reference to doctor-patient interaction, registration desk, waiting area, and overall health facilities. 95% of the patients reported being satisfied with the doctor and 89% said they would re-visit the hospital.[3]

Anup Singh (2019): A cross-sectional study was conducted among 100 eligible geriatric patients attending a government health care facility in Eastern Uttar Pradesh to assess the level of satisfaction among patients. A semi structured questionnaire was used which consisted of factors like interpersonal manner of health service providers, accessibility, physical environment, and quality of medical care. The study showed that there was a need to improve on manpower in outdoor clinic and better referral services so as to provide quality care to elderly patients.[2]

OBJECTIVES OF STUDY

1. To assess the quality of Geriatric Medicine OPD in a tertiary Hospital in Goa.
2. To assess the level of patient satisfaction visiting the Geriatric Medicine OPD.

METHODOLOGY

1. Source of Data Collection:
   a. Goa Medical College
2. Method of Data Collection: Structured Questionnaire
3. Duration of Study: till we attain the sample size or 6 months.
4. Study design: Cross sectional analytical study
5. Study Setting: Study will be conducted in the community of Goa
6. Recruitment: male or female adults
7. Proposed Sample size: 60
8. Sampling Method: Conventional

Eligibility criteria

a) Inclusion criteria:
   1. Both males and females.
   2. Age group: 60 years and above
   3. Residents of Goa
   4. Patients visiting Geriatric Medicine OPD.
   5. Willing to participate in the study.

b) Exclusion Criteria
   1. Age less than 60 yrs.
   2. Communication barrier and comprehension problem.
   3. Health staff attending the OPD.
   4. Unwilling to participate in the study.

Instrumentation: Modified version of Patient Satisfaction Questionnaire Short Form (PSQ-18).

Measurements: The participants will be interviewed with a modified version of a standardised questionnaire PSQ -18. The PSQ -18 contains 18 items tapping each of the seven dimensions of satisfaction with medical care measured by general satisfaction, technical quality, interpersonal manner, communication, financial aspects, time spent with doctor, accessibility and convenience. The PSQ- 18 was a short form version of the 50-item Patient Satisfaction Questionnaire III (PSQ- III). We modified the PSQ -18 according to our study settings. The questionnaire will contain 21 questions and scores for each question will range from 1 (strongly agree) , 2 (agree), 3 (uncertain) , 4 (disagree) and 5 (strongly disagree).

Procedure

Approval from the institution review board at Goa Medical College, Goa will be received before the commencement of data collection. Participants who meet the inclusion criteria will be chosen. The Modified version of Patient Satisfaction Questionnaire Short Form (PSQ-18). The participants will be explained the need of the study and consent will be taken from them before commencing the study. Once they give consent the participant will answer the Questionnaire so we can access the quality of the Geriatric OPD and will submit it to the investigator (A Lower Division Clerk). The investigators were not informed about the patients who gave negative consent to avoid bias of further treatment and quality of care.

RESULTS

The questionnaire in English, the consent in English, form and the master sheet are enclosed.

The results of the questions were grouped under a common heading and the results evaluated and plotted below.

Patient Satisfaction Questionaire

Sr No.	Question
01.	The doctors explain well about the disease condition.
02.	The doctors explain well about the tests and why they are needed.
03.	The OPD has everything to provide good medical care.
04.	The medical care received is just perfect.
05.	The doctors convince about the diagnosis and why the treatment is given.
06.	I feel that the physician check me well and I feel that they have examined me respectfully.
07.	I'm advised clearly about the tests and where they are to be done.
08.	I have an easy access if I'm referred to another specialty.
09.	I do not have to wait too long and there is enough sitting place.
10.	The doctors treat me with a lot of empathy and are not business like.
11.	The doctors approach is courteous and friendly and understanding.
12.	I like the way the doctor holds my pulse, this makes me feel in good hands.
13.	The doctor calls me by name which also is very assuring.
14.	The persons who offer medical care like the doctors, physiotherapists and occupational therapists are not in a hurry.
15.	They all have a lot of patience in explaining everything in the minute detail.
16.	None of my questions seem to irritate them.
17.	They answer all my queries without humiliating me and discouraging me.
18.	It is easy to get an appointment.
19.	I can go for queries without an appointment and I'm entertained.
20.	The character of all the doctors is the same and very encouraging.
21.	The clerk taking the appointments is very approachable.

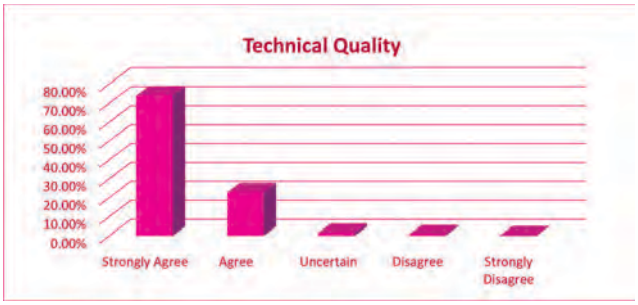
Domains	Questions Sr Nos from the questionnaire
General Satisfaction	4, 20.
Technical Quality	3, 5, 6, 12.
Interpersonal Manner	10, 11, 13, 16, 17.
Communication	1, 2, 7.
Time Spent with Doctors	14, 15.
Accessibility and Covenience	8, 9, 18, 19, 21.

General Satisfaction

Patients answer	Mean	Percentage
Strongly Agree	34.5	57.5
Agree	22.0	36.66667
Disagree	0.5	0.83333
Strongly Disagree	0	0

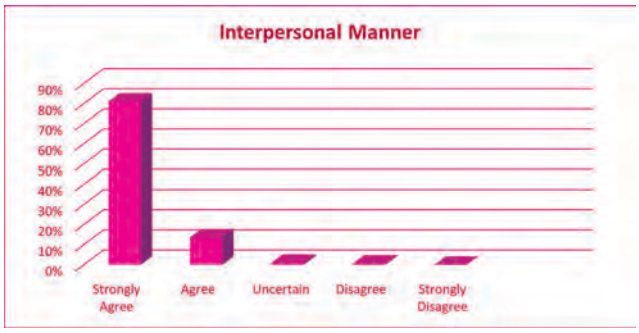
Technical Quality

Patients answer	Mean	Percentage
Strongly Agree	44.5	74.16667
Agree	13.75	22.91667
Disagree	1	1.666667
Strongly Disagree	0.5	0.833333



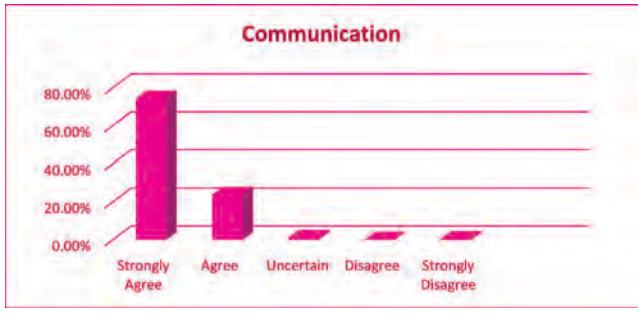
Inter Personnal Manner

Patients answer	Mean	Percentage
Strongly Agree	48.6	81
Agree	8.2	13.66667
Disagree	0.6	1
Strongly Disagree	0.4	0.66667



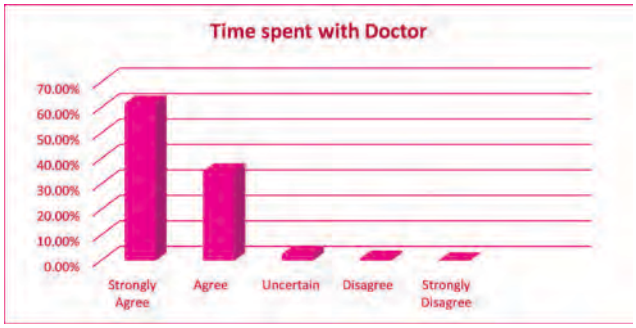
Communication

Patients answer	Mean	Percentage
Strongly Agree	44.6	74.33333
Agree	14.3	23.83333
Disagree	0.6	1
Strongly Disagree	0	0



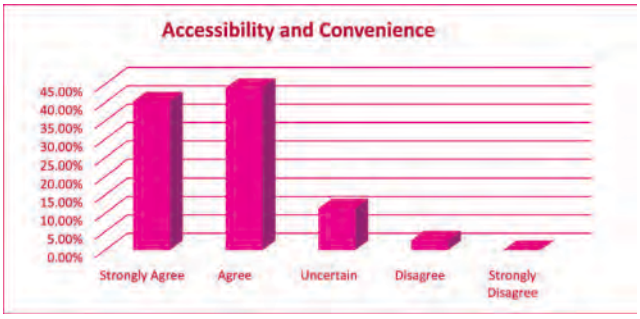
Time Spent with the Doctor

Patients answer	Mean	Percentage
Strongly Agree	37	61.66667
Agree	21	35
Disagree	1.5	2.5
Strongly Disagree	0.5	0.833333

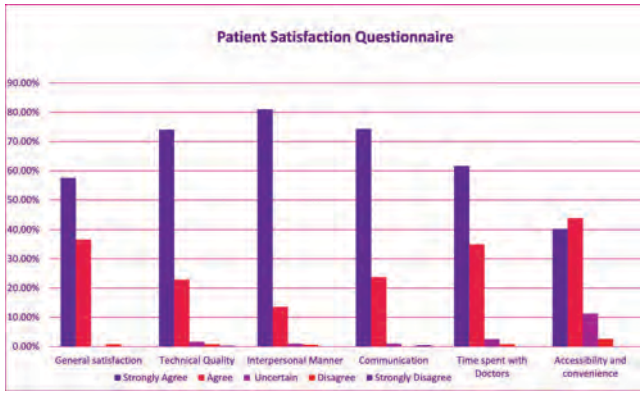


Accessibility and Convenience

Patients answer	Mean	Percentage
Strongly Agree	24.2	40.33333
Agree	26.4	44
Disagree	6.8	11.33333
Strongly Disagree	1.6	2.666667



Combined Graphs



As evident from the charts and from the data available,
In a study done by Taimur Saleem, Umair Khalid and Waris Qidway, in 380 geriatric patients attending the OPD, 79.2 % of patients felt that discussing treatment options and letting the patients take the final decision was seen, 84.5 % patients felt minimum medicines were prescribed, 79.2 % of patients felt that the physicians had a holistic approach to patient care and 85.5 % of patients felt they had a realistic and optimistic picture of future health.
In a study by Anup Singh, Patel and Sandeep, medium satisfaction was found in 56 % and low and high satisfaction was found in 23 % and 21 % patients respectively.
In a study by L Morishita, C Boult, L Boult, S Smith, J T Pacala, the geriatric patients found a 09 % more satisfaction as compared to general OPDs,
In General OPDs,
A study done by P Goyal, Deepak Kumar and others, 93.9 % of patients perceive the quality of services even in general OPD as good, 51.7% perceived good doctor behaviour and 35.4% good cleanliness.
A study done by Fatima Mukhtar on general OPD showed a similar perception, 94% showed satisfaction by the doctor, 94% found the hospital clean and 89% found the hospital staff respectful.
Our study showed that almost in all the domains the geriatric population were satisfied with the care that they received.
In the General Satisfaction 94% were satisfied,
In the Technical Quality Domain 97% were satisfied,
In the Interpersonal Domain 95% were satisfied,
In the Communication Domain 98% were satisfied,
In the Time Spent with the Doctor 97% and
In the Accessibility and Convenience Domain 84% were satisfied,

DISCUSSION

According to World Health Organization (WHO), level of satisfaction is an important tool to measure patient healthcare. In the present study the patient's satisfaction and Quality of Geriatric Medicine OPD in a tertiary care hospital in Goa was assessed as it gives an opportunity to see factors which could be emphasized to improve our services. It was a questionnaire-based study and answered by all adults who were attending the OPD.

Many studies have been done all over the world to evaluate patient satisfaction but minimal studies have been done in India with respect to the Geriatric population with no study been done in the state of Goa. In this study we have tried to consider 6 main domains: General satisfaction, technical quality, Interpersonal manner, Communication, Tine spent with the doctors, Accessibility and Convenience for our Goan population.

In the present study it was found that a majority of patients had a higher level of satisfaction compared to the other studies.

In the present study we found that technical quality, interpersonal manner and communication played a major role in affecting average satisfaction score. The patients were highly satisfied and reassured with the doctor's diagnosis treatment and the attention they received at the outdoor set up.

It was highlighted that the other domains, accessibility and convenience need to be focused more in order to get more satisfaction score.

This is an accurate finding as the location of the outdoor facility wasn't spacious and the doctors used to sit separately when we began our data collection. There used to be not

enough sitting place for the senior citizens with the appointment clerk sitting along with a clerk of another OPD hence causing inconvenience for the patients. However now the OPD settings has been shifted to a more spacious setting on the ground floor with the Consultant, Senior Residents and Residents sitting together.

The clerk has been given a separate counter exclusively for the Geriatric Medicine OPD making it more convenient for the patients to get an appointment and solve their queries. There is also enough sitting place for all the patients.

Limitation of the study includes a small sample size and use of only outpatient in determining the satisfaction level of patients. However, it does give an idea on areas which need improvement and emphasized upon.

CONCLUSION

The quality of Geriatric Medicine OPD and the overall satisfaction level of patients attending was moderate to high. Still there is need to improve on manpower in outdoor clinic and better referral services so as to provide quality care to elderly patients. A continuous system of patient feedback system should be used on regular basis to improve health facility for patients.

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Kinesiology in the Elderly: Understanding and Significance

M E Yeolekar*

INTRODUCTION

Kinesiology means the 'the study of movements '. Specifically, it studies the science of human movement, performance and function by applying the fundamentals of Cell Biology, Molecular Biology, Chemistry, Biochemistry, Biophysics, Biomechanics, Biomathematics, Biostatistics, Anatomy, Physiology, Exercise Physiology, Pathophysiology, Neuroscience and Nutritional Science. The Movement Science of "Kinesiology ", was created and coined in 1854.[1] by Carl August Georgii, then consisting two thousand physical movements and fifty different types of massage therapy techniques. Later the dual purpose was to encourage and promote the study and educational applications of the art and science of human movement and physical activity.

SCOPE

The scope of practice of kinesiology is defined as "the assessment of human movement and performance and its rehabilitation and management to maintain, rehabilitate or enhance movement and performance. "Kinesiology thus combines the study of biology and physiology with the study of human movement, primarily the three fields being biomechanics, musculoskeletal anatomy and neuromuscular physiology.

The three major principles of kinesiology include:

1. Adaptation through exercise- established and effective intervention for many movement disorders. Decreased risk of falls and increased neuromuscular control can be attributed to BALANCE intervention programs.[2]
2. Adaptive plasticity- greater amount of physical activity are associated with enhanced cognitive function in older adults.[3]
3. Motor Redundancy: A concept in kinesiology and motor control that states that for any task the human body can perform, there are effectively an unlimited number of ways the nervous system can achieve the task- kinematic, muscle and motor unit redundancy. Though several applications may appear in younger individuals in relation to exercise, fitness and sports, older adults and seniors can draw adequately from kinesiology. Kinesiologists can help seniors move as often as needed for them to regain their strength, confidence and independence. Being the scientific study of human movement, performance and function exercises can be designed that help patients prevent and treat illness or injury and also provide support in rehabilitation and wellness management.- post hospitalization, post cerebrovascular stroke or plain physical inactivity.

Reducing the risk factors for chronic disease and improving the quality of life for older adults by building awareness of the importance of physical activity is important and vital for the geriatric population.[4]

Techniques used in kinesiology include- acupressure, lymphatic massage, hypertonic muscle release, attention to reflex, trigger and body points. As persons turn older , it becomes more important to maintain strength and flexibility to continue to be independent with the activities of daily living. A simple squat or rising from the toilet can be arduous – kinesiologist helps build strength and resilience in human lives as they age. Elderly can benefit immensely from resistance training reducing the risk of falling and maintaining balance, coordination and bone density. Clinical frailty is diagnosed on combination of specific symptoms such as weight loss, muscle weakness/fatigue, low physical activity and slow walking speed.[5] Higher aerobic steps per day were more strongly associated with the lower prevalence and incidence of frailty compared to total steps /day, suggesting that faster aerobic walking may potentially provide greater benefits regarding frailty in older adults with hypertension.[6]

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Cefoperazone Sulbactum Causing Coagulopathy in Elderly

A known but rare and forgotten entity

Manisha Arora*, Prateek Gambhir**

A 79 year old female patient was brought to the emergency room with complaints of poor oral intake over couple of months along with recent onset symptoms of fever, shortness of breath and facial swelling since two days. She had a past history of coronary artery disease for which stenting was done 10 years ago. Her recent 2D Echocardiogram suggested severe systolic dysfunction with ejection fraction of 30% but no regional wall motion abnormality was detected. She had history of cerebrovascular accident in the past with Left hemiparesis from which she recovered completely. She was hypothyroid of 30 years duration and was taking 100mcg of Levothyroxin regularly. She was recently diagnosed as a case of vascular dementia about six months back. She gave history of fall in the bathroom around four months back following which she had become totally bed ridden and required Foley's catheter *in situ*. Although she hadn't had any evidence of fracture during this fall yet she had lost her confidence to walk. Family noted that she was losing her independence and was becoming more and more dependent on carers for the daily activities of living. However, she was able to make choices for the food and could rarely make a coherent conversation.

In Emergency room, general physical examination revealed a moderately built febrile lady with temperature of 102°F, heart rate of 128 beats per minute, regular, normovolumic with blood pressure of 110/70mm of Hg in right hand measured in supine state. She was dehydrated and had respiratory distress with respiratory rate of 28 per minute and oxygen saturation of 92% on ambient air. She was conscious, oriented and was responding well to all commands. She was pale, anicteric, had clinical signs of insulin resistance and also had bilateral pitting pedal edema. Chest examination showed bilateral vesicular breathing with evidence of fine inspiratory crackles in both basal areas. Cardiac examination showed tachycardia with normal heart sounds. There was no evidence of third or fourth heart sound. Rest of the systemic examination was normal.

Urobag showed small amount (100ml) of urine that was deep yellow and turbid in appearance. It had been emptied about 12 hours back and it pointed towards oliguria. Arterial blood gas analysis was suggestive of uncompensated metabolic acidosis with increased lactate levels of 8 mmoles/L. Cardiac markers were negative except BNP was 1580.

Patient was admitted in medical intensive care unit with the probable diagnosis of Urosepsis with precipitation of acute left ventricular failure with underlying cardiovascular and cerebrovascular events and vascular dementia. She was started on slow IV fluids based on fluid status of the body that was ascertained by clinical examination and serial measurements of central venous pressure & inferior vena cava by ultrasound. Broad spectrum antibiotics in the form of combination of Meropenem and Teicoplanin in the appropriate doses for her age were started. She was also started on diuretics in the form of furosemide with serial dynamic clinical examnation to assess the fluid status. Antiplatelet drugs were started along with the supportive treatment including NG tube for feeding.

Hematological and biochemical routine investigations revealed hemoglobin of 11.2gm%, leucocytosis of 12,000/cu mm with neutrophilic predominance of 91%. Kidney function tests and Liver function tests were normal along with Prothrombin test (PT) that was 13.4 seconds and International Normalized Ratio (INR) was 1.129. C Reactive Protein (CRP) was 250mg/dL and Procalcitonin was 42.5. Urine routine examination showed field full of WBCs (pus cells) per high power field. Blood culture and hepatitis markers were unremarkable. Echocardiogram showed moderate diastolic dysfunction(grade 2) with severe systolic dysfunction of 25-28%. There was growth of E.coli $>10^5$ CFU/ml sensitive to cefoperazone/ sulbactum combination, Amikacin, Fosfomycin and all drugs of Penem group.

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After receiving urine culture report, Teicoplanin was stopped. CRP had remarkably decreased to 49mg/dL and procalcitonin too had impressively decreased to 4.0 on receiving five days of antibiotics (Meropenem). In view of the encouraging biochemical parameters, antibiotic-meropenem was de-escalated to cefoperazone /sulbactam combination which was continued for next five days. Patient showed remarkable improvement clinically except that her dementia had worsened and her oral intake continued to remain poor and she was totally dependent on enteral feeding.

Before discharge, it was discussed with family and decided to insert percutaneous endoscopic gastrostomy feeding (PEG) tube to resolve the long term feeding issue to take care of nutritional needs of the patient. Before the procedure, PT/INR was done as a matter of routine which came as PT 57.8 seconds and INR 5.013. She never had any evidence of liver disease, obstructive jaundice or any other intestinal disease disrupting intestinal flora. Warfarin and heparin were not being used in this patient. Thus, after excluding all possibilities, Cefoperazone/sulbactam was thought to be the culprit and was withheld immediately. It was replaced by oral preparation of 3rd generation cephalosporin in the form of Tablet Cefixime. She received Vitamin K for three days and PT/INR value was repeated that was found to be within normal limits as it was at the time of admission. She underwent PEG feeding tube insertion and was discharged home in a satisfactory state.

DISCUSSION

Cefoperazone (CPZ)/sulbactam is a combined formulation of a third-generation cephalosporin and a β- lactamase inhibitor, which is mostly administered to treat severe bacterial infections. Cefoperazone/sulbactam has low nephrotoxicity and high safety but a long-term high-dose use may lead to vitamin K-dependent coagulation dysfunctionin patients.

Potential mechanism of coagulation dysfunction resulting from Cefoperazone/ sulbactam might be as follows: (1) affects the intestinal synthesis of vitamin K2 and (2) interferes with the gamma carboxylation of vitamin K-dependent clotting factors because it might inhibit vitamin K epoxide reductase and reduce the availability of vitamin K, although the evidence is not conclusive. Thus, CPZ was thought to reduce the synthesis of vitamin K-dependent clotting factors, such as II, VII, IX, and X, resulting in a functional deficit of these factors in humans.

Cefoperazone has a methylthiotetrazole side chain which on metabolism produces free N- methylthiotetrazole (NMTT). NMTT has been reported to cause coagulation disorder and hemorrhage by reducing levels of vitamin K and prolong PT by inhibiting vitamin K epoxide reductase. The clotting profile should be monitored, and a vitamin K supplement may be required to prevent hemorrhagic complications.

Hyperprothrombinemia is a relatively uncommon event in hospitalized patients. When it does occur, it often is associated with surgery, dietary vitamin K deficiency, renal dysfunction, malignancy, and broad-spectrum antibiotic therapy. A study by Strom et al has noted the frequency of bleed at various sites secondary to cefoperazone administration. The most frequent site of bleeding was from the urinary tract, and more than 75% of cases of bleeding were microscopic. The second most frequent site was the integument, then bleeding from the nose, mouth, or pharynx, then the digestive system.

CONCLUSION

Isolated prolongation of prothrombin time following Cefoperazone administration and rapid correction following vitamin K supplementation is suggestive of Cefoperazone induced coagulopathy. There is evidence that cefoperazone-sulbactam is associated with an increased risk of PT prolongation and coagulation disorder especially in elderly population. Life threatening complications associated with this coagulopathy can be prevented by serially monitoring coagulation parameters and vitamin K suplementation.

To prevent cefaperazone/sulbactum combination induced vitamin K-dependent coagulopathy, it is suggested to avoid this drug in elderly patients with a high risk of bleeding unless the need is compelling.

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A Retrospective Study on use of Ambulance Services by Elderly in Selected States in India

G.V. Ramana Rao*, Aruna Gimkala**

INTRODUCTION

The World Health Organization (WHO) has defined quality of life (QoL) as "an individual's perception of life in the context of culture and value system in which he or she lives and in relation to his or her goals, expectations, standards, and concerns".[1] National Elderly Policy defines person of 60+ age group as elderly. According to the Population Census 2011 there are nearly 104 million elderly persons (aged 60 years or above) in India.[2] A report released by the United Nations Population Fund suggests that the number of elderly persons is expected to grow to 173 million by 2026. The share of the elderly in the population is expected to increase from 8.6 percent in 2011 to 20 percent of the population by 2050. Senior citizens or elderly health is also generally influenced by many socioeconomic factors. Their vulnerabilities stand further exposed during pandemics, disasters, and calamities. Lack of awareness, inadequate healthcare training, and limited resources pose challenges to healthcare in old age.[3]

Emergency Management and Research Institute Green Health Services (EMRI GHS) has been providing comprehensive emergency services in partnership with various state governments by running a single toll-free number, 108, in 16 states and union territories across India. Elderly people often face various medical emergencies, such as cardiovascular disease, stroke, falls, and respiratory infections. These conditions can be life-threatening and require immediate medical attention. It is important for elderly people to have access to timely and effective prehospital care in the event of a medical emergency. This can include ambulance services, telemedicine, and other forms of emergency medical support. This study was aimed on the elderly utilizing 108 services to describe the socio-demographics, type of emergencies reported, and patient condition during prehospital care and type of hospitals elderly patients were admitted to be the key variables in this study.[4]

MATERIALS AND METHODS

Methods: A retrospective observational study method was adopted to conduct the analysis of the emergency call and admitted to hospital records for this study.

Study participants: Distress callers aged 60 and above years complained of all types of emergencies and decided to avail the toll free number 108 emergency ambulance services.

Setting: Emergency Management and Research Institute Green Health Services (EMRI GHS) operating three states included in this study namely Assam, Gujarat, and Kerala in India.

Study period: One year (January 01 to December 31, 2021).

Data source: Computer Telephonic Integration (CTI) data obtained from Emergency Response Center (ERC) of EMRI GHS in three operating states of Assam, Gujarat and Kerala.

Data analysis: Emergency calls records of elderly were analyzed and the frequencies or number (N/n), percentages (%), and means were calculated using Microsoft Excel to describe the findings of this study.

Abbreviations and symbols:

EMS - Emergency Medical Services

EMRI GHS - Emergency Management and Research Institute Green Health Services

CTI - Computer Telephonic Integration

ERC - Emergency Response Center

N – Number

% - Percentage

RESULTS

A total study sample of (N=169734) emergency calls reported and used 108 services by elderly age group 60 and above years and who were admitted to the hospital from the

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three operating states shared namely Assam (10899, 6.4%), Gujarat (105831, 62.4%) and Kerala (53004, 31.2%) of EMRI GHS were included and analyzed for the study findings during 2021. Socio-demographical distribution showed following key findings. Overall mean age of the elderly study population was 69.5 years. Gender wise (54.2%) were males and females (45.8%). Elderly age group (60-69 years) accounted for the most (53.7%) and the least with (90 + years) with (2.4%). Incident area wise majority of the elderly patients were from rural (45.9%), urban (45.4%), tribal (6.5%) and difficult terrain (2.2%) areas from the three states. Highest reported type of emergency calls were related to COVID-19 (suspected) with (46.8%), followed by top five emergencies were (14%) breathing problem, (8.6%) abdominal pain, (8.2%) trauma (non-vehicular), (6.8%) cardiac and (4.4%) of trauma (vehicular) cases. Majority of the patient's condition during ambulance transport was non-critical (87.9%) and critical (12.1%). Type of hospitals elderly patients were admitted to be mostly government (86.8%) and private (13.2%) hospitals from the total elderly population of the study.

State wise distribution of socio-demographic profile is shown in the table 1.

State wise distribution of type of emergencies reported to 108 services was shown in the table 2

State wise distribution of condition and type of admitted hospitals were shown in table 3.

DISCUSSION

A retrospective study was carried out among geriatric populations utilizing 108 services in the states of Assam, Gujarat and Kerala during 2021. The mean age of the elderly study population was 69.5 years. Elderly male (54.2%) population outnumbered females (45.8%) total sample but from the state Kerala females accounted for (51.5%) in the present study. Elderly patients were admitted mostly to the

Table 1: State wise distribution of socio-demographic profile of the elderly population

Characteristics	Assam Total (n)	Assam (n %)	Gujarat] Total (n)	Gujarat (n %)	Kerala Total (n)	Kerala (n %)	Total Sample (N)	Total Sample (N %)
Elderly Emergency Calls	**10899**	**6.4**	**105831**	**62.4**	**53004**	**31.2**	**169734**	**100.0**
Age (years)								
60-69	6691	61.4	57547	54.4	26911	50.8	91149	53.7
70-79	3002	27.5	32029	30.3	16997	32.1	52028	30.7
80-89	1025	9.4	13660	12.9	7720	14.6	22405	13.2
90 +	181	1.7	2595	2.5	1376	2.6	4152	2.4
Mean Age	**67.8**	**0**	**69.1**	**0**	**70.5**	**0**	**69.5**	**0**
Gender								
Male	6522	59.8	59703	56.4	25726	48.5	91951	54.2
Female	4377	40.2	46128	43.6	27278	51.5	77783	45.8
Area								
Rural	8801	80.8	34657	32.7	34511	65.1	77969	45.9
Urban	2098	19.2	60216	56.9	14714	27.8	77028	45.4
Tribal	0	0.0	10958	10.4	0	0.0	10958	6.5
Difficult Terrain	0	0.0	0	0.0	3779	7.1	3779	2.2

Table 2: State wise distribution of type of emergencies reported to 108 services by elderly population								
Type of Emergencies	**Assam Total**	**(%)**	**Gujarat Total**	**(%)**	**Kerala Total**	**(%)**	**Total**	**(%)**
Elderly Sample	**10899**	**6.4**	**105831**	**62.4**	**53004**	**31.2**	**169734**	**100.0**
Abdominal Pain	861	7.9	13225	12.5	440	0.8	14526	8.6
Allergic Reactions	2	0.0	177	0.2	3	0.0	182	0.1
Behavioral Problem	2	0.0	133	0.1	4	0.0	139	0.1
Breathing Problem	5178	47.5	18055	17.1	525	1.0	23758	14.0
Cardiac	853	7.8	10310	9.7	397	0.7	11560	6.8
Convulsions/(Fits)	14	0.1	2575	2.4	85	0.2	2674	1.6
COVID-19-Suspected	1907	17.5	27237	25.7	50319	94.9	79463	46.8
Diabetic Problem	158	1.4	5416	5.1	170	0.3	5744	3.4
Environmental	1	0.0	25	0.0	0	0.0	26	0.0
High Fever	348	3.2	4131	3.9	51	0.1	4530	2.7
Inaccessible Incident	3	0.0	448	0.4	0	0.0	451	0.3
Poisoning /(Toxicology)	44	0.4	783	0.7	16	0.0	843	0.5
Severe Acute Malnutrition	0	0.0	17	0.0	1	0.0	18	0.0
Severe Headache	10	0.1	281	0.3	1	0.0	292	0.2
Stroke/(Paralysis)	554	5.1	3407	3.2	187	0.4	4148	2.4
Trauma (Non-Vehicular)	633	5.8	12820	12.1	530	1.0	13983	8.2
Trauma (Vehicular)	331	3.0	6791	6.4	275	0.5	7397	4.4

Table 3: State wise distribution of condition and type of admitted hospitals of the elderly population								
Characteristics	**Assam Total (n)**	**Assam (n %)**	**Gujarat Total (n)**	**Gujarat (n %)**	**Kerala Total (n)**	**Kerala (n %)**	**Total Sample (N)**	**Total Sample (N %)**
Admitted Sample	**10899**	**6.4**	**105831**	**62.4**	**53004**	**31.2**	**169734**	**100.0**
Patient Condition								
Critical	2522	23.1	16628	15.7	1314	2.5	20464	12.1
Non-Critical	8377	76.9	89203	84.3	51690	97.5	149270	87.9
Hospital Type								
Government	10601	97.3	84819	80.1	51926	98.0	147346	86.8
Private	298	2.7	21012	19.9	1078	2.0	22388	13.2

government (86.8%) hospitals. in this study. Similar findings were seen in the studies carried out by Shah, et al., almost three fourths (76%, n = 190) of geriatrics preferred government health facility for treatment of various illnesses. Female preponderance was found in our study with 57.6% as compared to males (n = 106, 42.4%).[1] Elderly age group 60-69 years mostly accounted for (53.7%) in this study. Similar findings were seen in the studies carried out by Gupta A, Girdhar S, Chaudhary A, et al., majority of the subjects belonged to age group of 60-69 years (70%).[5] Most of the elderly populations were from rural areas in this study. Similar findings were seen in the studies carried out by Dey S, Nambiar D, Lakshmi JK, et al. the majority of elderly reside in rural areas, belong to low SES, and are dependent upon their families.[6] The most reported emergencies were COVID-19 suspected (46.8%) followed by (14%) breathing problem in this study. Similar statement of the COVID-19 affect on elderly was found in the survey report (Needs of older people in India. A Review March 2021). In view of ongoing Covid-19 threat, during the survey it was also attempted to assess the impact of the Pandemic on elderly. Most elderly i.e. 29.5% elderly respondents claimed that the Pandemic has largely affected their social life. 26.0% elderly respondents claimed that Covid-19 situation has affected their health condition most and ranked it as their premier cause of concern.[3] In order to address variety of challenges faced by elderly population, there is a strong need for well-conceived approach towards new age older persons and better Preventive programs, specifically targeting the elderly should be implemented.

CONCLUSION

This prehospital study on elderly patients reveals that the COVID-19 suspected and breathing problem emergencies was the leading cause for seeking EMS services during the study period of the 2021. Rural elderly were significantly benefited. Majority of the elderly were transported through 108 ambulances and admitted to hospitals. Detailed research linking ambulance based prehospital care and post hospitalization outcomes and impact are needed to develop relevant insights into geriatric emergency care in India.

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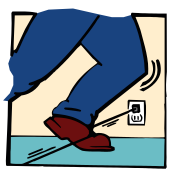
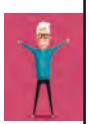
PRACTICAL TIPS

Prevention of falls in Elderly

Dr. Sandeep Kumar *, Dr. Anand P. Ambali**

Do's and Dont's in preventing a fall.

Things to do	Do's	Things to do	Do's
• If you are feeling dizzy or swaying while walking use stick or walking aid		• Drink at least one glass of milk daily and have foods rich in calcium.	
• Keep light "on" in bathroom during night.		• Get bar grabs fitted by side of commode. Keep bathroom dry. Use mattress on floor of bathroom to avoid slips.	
• In case of vision disturbance, kindly consult ophthalmologist and get it corrected. Use hearing aids regularly, if you are advised.		• On stair case, Top and Bottom steps marked with different colour. The hand rail should be different colour.	
• Keep soft mattress under the cot in night hours. In case even if you fall, you will not sustain injuries.		• Medications – Drugs meant for control of Hypertension, Diabetes should be taken regularly	
• Remove clutters like wires. The wires or torn rugs will lead to fall, hence avoid using low set electrical pins.		• Keep all the items of daily use preferably on the table of equal height which can be reached easily.	
• Use bed rails. These rails should be one third of cot length, flexible and can be used during sleep time.		• Go for periodic check up of blood pressure and sugar levels. Look for orthostatic hypotension and hypoglycaemia and discuss with consultant.	
• Spend time in sunlight. The exposure to sunlight preferable between 11am to 2pm for 15 to 30minutes is ideal. It helps formation of Vitamin D in body.	 	• Place a call bell near wash basin or toilet easily accessible.	
• Walking is the best exercise. Walk at least 30 minutes for five days a week. This gives strength to muscles and helps maintain balance.			

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Things to do	Don't's
• Alcohol intake. It leads to falls	
• Benzodiazepine drugs (Diazepam, Alprazolam) If you are consuming more than five drugs, you are at risk of falls.	
• Do not walk on wet floors. Also be careful while walking on unequal pavement on the roadside.	
• Do not use ladder. Avoid using stools or ladder to climb for getting items placed at high level.	
• Do not get down the stairs. Instead use escalator. Older people are more likely to fall while getting down the stairs.	
• Do not use glasses with bi-focal lens. Make two different glass one each for short sight and another for far sight.	
• Do not use loose and ill fitting slippers and slippers of the other person.	

News from Vijayapura

Department of Geriatric Medicine
Report of Guest Lecture organised on 05/11/2022

The BLDE (Deemed to be University), Shri B. M. Patil Medical College Hospital & RC, Vijayapura, Department of Geriatric Medicine, Association of Physicians of India, Vijayapura Branch, & Geriatric Society of India, Delhi jointly organised guest lecture on 5/11/2022 between 10.30AM to 12.15PM in Medical Education Hall.

Dr Anand P Ambali welcomed the gathering and gave a preamble to Pulmonary Embolism, and challenges in elderly patients.

The faculty Dr. Veerendra M. Chadachan, MD, MRCP (UK), FAMS (Singapore) ABVM(USA), EBAVM(Europe) is Senior Consultant, in Department of Vascular Medicine & Hypertension Section, at Tan TockSeng Hospital, Singapore.

The Topic for discussion was "Acute Pulmonary Embolism – Challenges in Diagnosis and Management".

Dr. Chadachan discussed in depth regarding Pulmonary Embolism, the challenges clinician faces in diagnosis, various investigation modalities including its advantages and disadvantages and management. He also emphasized on preventive measures of embolism in ICU setup. He also had interactive session for discussion of challenging cases.

Dr. L. S. Patil, Professor of Medicine, Secretary, API Vijayapura Branch chaired the session. The number of delegates participated is 54.

Certificate and A book published by Geriatric Clinic were presented to the Speaker and Chairperson. Dr. Mudassir, Assistant Professor proposed Vote of Thanks.

Hight tea was served.

Guest Lecture on Acute Pulmonary Embolism – Challenges in Diagnosis and Management

GSI Vijayapura Organised guest lecture on **Acute Pulmonary Embolism – Challenges in Diagnosis and Management.**

Speaker Dr Veerandra Chadachan, Singapore

Dr A P Ambali was invited faculty for webinar organised by National Institute of Social Defence, GOI on 31/10/2022

The topic was Care of Elderly in Old Age Home

Dr A P Ambali was invited resource person for training medical officers of Vijayuapura District on Geriatric Care and NPHCE on 27/9/2022

Dr A P Ambali was invited faculty at VII world congress on Geriatric and Geriatric Medicine organised by Biogenesis on 2/10/2022. Topic was Preventive Geriatrics

GSI Vijayapura was awarded with Appreciation Award from GSI at GSICON Kolakta on Dec 2, 2022.

News from Odisha

Proceedings of the GB meeting of GSI, Odisha State Branch held on 11th September 2022 at Auditorium, SJMCH, Puri.

I am glad to inform you that a GB meeting was held under the Chairmanship of Dr Dhirendranath Moharana at the Auditorium of Shri Jagannath Medical College, Puri on 11.09.2022 during the Geriatric CME 2022 at SJMCH, Puri. As per the GB meeting proceedings the following Office bearers were assigned their responsibilities for the newly formed society of GSI, Odisha State Branch.

Office Bearers are as follows:

Patron: Dr Dhirendranath Moharana

Advisor: Dr Biranchi Narayan Mohapatra

Chairman: Dr Purna Chandra Dash

Vice Chairman: Dr Jayanta Kumar Panda

General Secretary: Dr Prasanna Kumar Rathor

Joint Secretary: Dr Santosh Kumar Swain

Assistant Secretary: Dr Biraja Prasad Biswal

Treasurer: Dr. Ashok Kumar Behera

Executive Committee Members:

1. Dr. Namita Mohapatra;
2. Dr. Ashok Kumar Parida;
3. Dr. Amulya Kumar Das

Dr Prasanna Kumar Rathor
General Secretary
GSI, Odisha State Branch
Email: drpkrathor135@gmail.com
Mobile: 943710911

Geriatric CME in Puri, Odisha

Report by Dr. Kaushik Ranjan Das

A day long Geriatric CME was conduced on 11.09.2022 at the auditorium of Sri Jagannath Medical College, Puri ,Odisha; being organized by GSI Eastern Zonal branch and GSI Odisha branch, in collaboration with Staff Academic Society, SJMC, PURI. Chief Guest was Principal & Dean SJMC, Madam Maya Padhi. Other personalities were: Dr. Thoidingiam Bijoy Singh (Monipur), Dr. Taruni Ngangbam (Manipur), Dr. Soumik Ghosh, Dr. Aniruddha De, Dr. D. N. Maharana & Dr. Kaushik Ranjan Das. Dr. Purna Chandra Dash was the Chairman at the Inauguration. There have been 08 (eight) scientific sessions, those were hugely participatory. More than 100 doctors (Faculty and delegates) joined the CME. Dr. Santosh Kumar Swain has done outstanding job and has been instrumental. Other persons, Dr. Purna Chandra Dash, Dr. Prasanna Kumar Rathor and Dr. Aniruddha De have done wonderful motivational work toward furtherance of Geriatrics and GSI. Three persons- Dr. Purna Chandra Dash, Dr. Prasanna Kumar Rathor and Dr. Santosh Kumar Swain were awarded appreciation award from GSI HQ. By the grace of Lord Sri Jagannath, the conference was a grand success.

News from Pune Chapter

GBM of the GSI Pune Chapter

We conducted GBM of the GSI Pune Chapter on 21 st August 2022.

Following members were present- Dr. Sandeep Tamane, Dr. Pramod Umaraji, Dr. Surekha Chavan, Dr. Smita Athavale, Dr. Samir Khaire, Dr. Shubhangi Kanetkar, Dr. Sushma Jadhav, Dr. Vandana Kakarani

In this meeting, it was decided unanimously to dissolve Current Managing Committee of GSI Pune Chapter. Also, Current Vice Chairperson of the GSI Pune Chapter, Dr. Lata Bhoir was unanimously selected as the next Chairperson of GSI Pune Chapter.

Dr. Bhoir will be selecting her team (new Office bearers). Dr. Bhoir could not attend the meeting due to unavoidable professional commitments and had Informed us in advance about this.

However, the decision was conveyed to her by the Secretary Dr. Surekha Chavan telephonically and Acceptance from Dr. Bhoir was obtained.

We sincerely thank GSI Head Quarters and both of you for the opportunity given to us to work at both local and National level and request you to do this in future as well.

Dr. Sandeep Tamane, Chairman, GSI Pune Chapter.

Dr Pradnya Diggikar was speaker at Seventh World Congress in Gerontology and Geriatrics organised by Biogenesis at Bangalore Topic Geriatric Giants & World Congress on Non-Communicable Diseases 2022

Annual Conference GSICON 2022 Kolkata

– A photo report by Dr. Kaushik Ranjan Das

Chief Guest at Inauguration programme Mrs. Leena Gangopadhyay, Chair Person, Woman's Commission, GOVT of West Bengal

Dr. Dhires Kumar Chowdhury (Media convenor, GSI WB branch) receiving award from Inaugurator Prof (Dr.) Surhita Paul, Vice Chancellor, WBUHS

Dr. Sajesh Asokan, (GSI, Executive committee) receiving award from Dr.S. Neogi, Director Health Services, Govt of West Bengal

Dr.Purna Chandra Das (Chairman,GSI Odisha branch) receiving award from Inaugurator.

Dr.Surekha Chavan receiving award from Dr.Kaushik Ranjan Das,President GSI

Dr.Anand P Ambali receiving award from Inaugurator.

Dr.Aniruddha De (Organizing Secretary,GSICON'22) receiving award from Guest of honour Dr. Debashish Bhattacharya,Director Medical Education, Govt of WB

Dr.Rahul Bhattacharyya(Organizing Secretary,GSICON'22) receiving award from Guest of honour Sakuntala Barua(Eminent actress)

Dr.Rana Mukherjee ,receiving award from Director Health Services at inauguration programme

Dr.Shyama Prasad Roy receiving award from Chief Guest

Dr.Mainak Gupta (Treasurer,GSI WB branch) receiving award from Director Medical Education

Dr.Krashnanjan Chakraborty (General Secretary,GSI WB branch) receiving award from inaugurator. Dr.V.K.Arora (Patron GSI in the middle).

President GSI offering flower bouquet to panelist Ms. Tanusree Guha.

President GSI offering flower bouquet to panelist Dr.Vivek Handa (Past President and Advisor GSI)

Chief Guest offering flower bouquet to Madam Santi Sharma, Eminent writer and social activist.

Dr.P.V.Pravakar Rao (GSI executive committee) receiving flower bouquet from inaugurator

Chief guest offering flower bouquet to Mrs.Indrani Chakraborty (Chief functionary, CMIG,Kolkata)

Dr.Sushanto Ghosh (GSI Member, Bangladesh) receiving flower bouquet from inaurugator

Dr. Mohit Sharma (Speaker at GSICON'22) receiving flower bouquet from inaugurator

Dr. Atul Kulsreshtha (Speaker/Faculty at GSICON'22) receiving flower bouquet from inaugurator.

Dr.Vivek Handa receiving flower bouquet from inaugurator

Dr.Krishnanjan Chakraborty offering gift and flower bouquet to President GSI.

Chairman,GSI WB branch ,Dr.Chinmoy Kumar Maity offering gift and flower bouquet to Patron GSI, Dr.V.K.Arora

Dr. Dhires Kumar Chowdhury felicitating Chief Guest

Dr. Garima Handa (Treasurer, GSI) receiving flower bouquet from inaugurator.

Members of GSICON'22 organizing committee with Patron GSI, Dr. V.K.Arora

Organizers and dignitaries including Dr. O.P. Sharma (General Secretary, GSI) at inauguration (lighting the lamp)

Dr. Kaushik Ranjan Das ,President GSI

GSI Patron Dr.V.K.Arora(left) and GSI General Secretary Dr.O.P.Sharma, Putting on Dr.K.Shankar Oration Medallion.

Lamp lighting at the inauguration

Inauguration of scientific programme on 02.12.22 morning.

Blessings showered(virtually) by Chief Patron GSI, Dr.P.S.Shankar at inauguration of scientific programme.

Dr.Krishnanjan Chakraborty, General Secretary GSI WB branch addressing the audience at inauguration of scientific programme.

Dr.Kaushik Ranjan Das delivering presidential oration.

Audience at Workshop

Audience at Workshop

Audience at Workshop

Audience at Workshop

Certificate recipient GSI certificate course Version II

Certificate recipient GSI certificate course Version II

Certificate recipient GSI certificate course Version II

Certificate recipient GSI certificate course Version II

Group Photo ,certificate recipient and faculty

Certificate recipient GSI certificate course Version II

Group photo of organizing committee members with Patron GSI Dr.V.K.Arora

Prof (Dr.) Arunansu Talukdar (Organizing Chairman GSICON'22) felicitating Inaugurator Prof (Dr.) Suhrita Paul

Release of conference souvenir at inaugural function

GSI President offering oration medallion to Prof (Dr.) Pratibha Pereira

Release of Tuberculosis journal at inauguration

3rd prize recipient of poster display(Doctor)

Winner of poster presentation (Nurse)

Winner of poster presentation (Nurse)

Winner of poster presentation (Nurse)

Dr.Kaushik Ranjan Das receiving certificate of oration.

Stalls by Pharmas at conference venue.

Dr.Sajesh Asokan receiving certificate of oration from Dr.Subhangi Kanitkar (Chairperson of the session)

Dr.A.K.Singh delivering oration ; Dr.H.S.Pathak and Dr.Atul Kulshrestha chairing the session.

Moment of the day- Dr.B.K.Mondal showering blessings on Dr.Kaushik Ranjan Das and Dr.O.P.Sharma; standing behind Dr.Hrishikesh Kumar

Great moment- Dr.O.P.Sharma showering blessings on Dr.Partha Ray (UK) ,on left side chairperson Dr.Joydeep Mukherjee and on right side speaker Dr.Bindu Menon.

Audience at Workshop

Dr.Asoke Das and Dr. Chinmoy Kumar Maity (Chairpersons)

Prof(Dr.) Suhrita Paul ,Inaugurator addressing the auduence at Inauguration.

From left to right: Dr.Arnab Duari (speaker), Dr. Himadri Das offering memento, Dr.Rajiv Garg and Dr.A.K.Singh (Chairpersons)

Memento giving,from left to right: Dr.N N Prem (chairperson) Dr.Atul Kulsreshtha(Speaker) & Dr.I.S.Jain (Chairperson)

Memento giving,from left to right: Dr.Mohit Sharma (Speaker),Dr.Asoke Das & Dr. Samudra Gooptu (Chairpersons)

Dr. P V Pravakar Rao delivering his talk.

From left to right: Dr.Sunip Banerjee(speaker), Dr.Surendra Daga and Dr.Rajinder Singh Gupta

Dr.H.K.Rao delivering her talk at GSICON'22

Dr.Rahul Bhattacharyya offering memento to speaker Dr.Anupama Murthy

Dr.O.P.Sharma offering memento to faculty (Left to right) ,Dr.Joydeep Mukherjee,Dr.Bindu Menon and Dr.Partha Ray (UK)

Dr.Anand P Ambali delivering his talk

Dr BK Mondal being felicitated

Speaker Dr.Awdesh Kumar Singh (Endocrinologist)

Speaker Dr.Subir Roy taking speaker's memento from chairperson Dr. Biswajit Ghosh Dastider

Dr.J J Mukherjee receiving speaker's memento from chairpersons Dr.Biswajit Ghosh Dastider and Ravi Kant Saraogi(left to right)

Partcipants taking lunch

Audience at Hall 1

Dr.Rahul Bhattacharyya as speaker.

Dr. Debasish Chatterjee in Hall-2

Chairpersons Dr.Lochana Shreshtha (Nepal) on left and Dr.Indrani Chakraborty(CMIG) right

Speaker Dr.Purna Chandra Dash

From left to right :Speaker Dr.Taruni Ngangbam , Chairpersons: Dr.Kaushik Ranjan Das and Dr. Lochana Shreshtha(Nepal)

Dr. Sajesh Asokan receiving institutional certificate for Certificate course of GSI version II

Dr.Prabha Adhikari receiving certificate as faculty of certificate course of GSI version II

Dr.Sajesh Asokan receiving certificate as faculty of certificate course of GSI version II

Dr.Kaushik Ranjan Das receiving certificate as faculty of certificate course of GSI version II

Dr.Chinmoy Kumar Maity receiving certificate as faculty of certificate course of GSI version II

Dr.Krishnanjan Chakraborty receiving certificate as faculty of certificate course of GSI version II

Dr.Sandeep P Tamane receiving certificate as faculty of certificate course of GSI version II

Dr.Pratibha Pereira receiving certificate as faculty of certificate course of GSI version II

Dr.Prabha Adhikari receiving certificate as faculty of certificate course of GSI version II

Dr.Anita Kumar receiving certificate as faculty of certificate course of GSI version II

Dr.Vivek Handa receiving certificate as faculty of certificate course of GSI version II

Dr.Asutosh Deshpande receiving certificate as faculty of certificate course of GSI version II

Dr.Anupama Murthy receiving certificate as faculty of certificate course of GSI version II

Dr.Kaushik Ranjan Das receiving certificate as faculty of certificate course of GSI version II

Dr.O.P.Sharma receiving certificate as faculty of certificate course of GSI version II

Dr.Garima Handa receiving certificate as faculty of certificate course of GSI version II

Dr.Mohit Sharma receiving certificate as faculty of certificate course of GSI version II

Dr.Smitha Athavale receiving certificate as faculty of certificate course of GSI version II

Dr.Ramana Rao GV receiving certificate as faculty of certificate course of GSI version II

Dr.Purna Chandra Dash receiving institutional certificate for certificate course of GSI version II

Dr.Sandeep P Tamane receiving institutional certificate for certificate course of GSI version II

Dr.Pradyna Mukund Diggikar and Dr. Subhangi Kanitkar receiving institutional certificate for

Dr.Purna Chandra Dash receiving certificate as faculty of certificate course of GSI version II

Dr.Arunansu Talukdar receiving certificate as faculty of certificate course of GSI version II

Dr.Subhangi Kanitkar receiving certificate as faculty of certificate course of GSI version II

Dr.Pradyna Mukund Diggikar receiving certificate as faculty of certificate course of GSI version II

Dr.Pratibha Pereira receiving certificate of oration at GSICON'22

Dr.B.K.Mondal (UK) as speaker and Dr.Sushanto Ghosh (Bangadesh) as chairperson

Dr. Suvro Banerjee as speaker (left) and Dr. R.N.Maiti as chairperson (right)

President GSI and General Secretary GSI on the dais at GB meeting on 3.12.22

Esteemed members of GSI at GB meeting on 03.12.22 at GSICON'22

Fellows of GSI elected in 2022

Dedicated to Geriatric Care

With Best Compliments From

Dr. Satish Gulati
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Consultant Physician & Geriatrician
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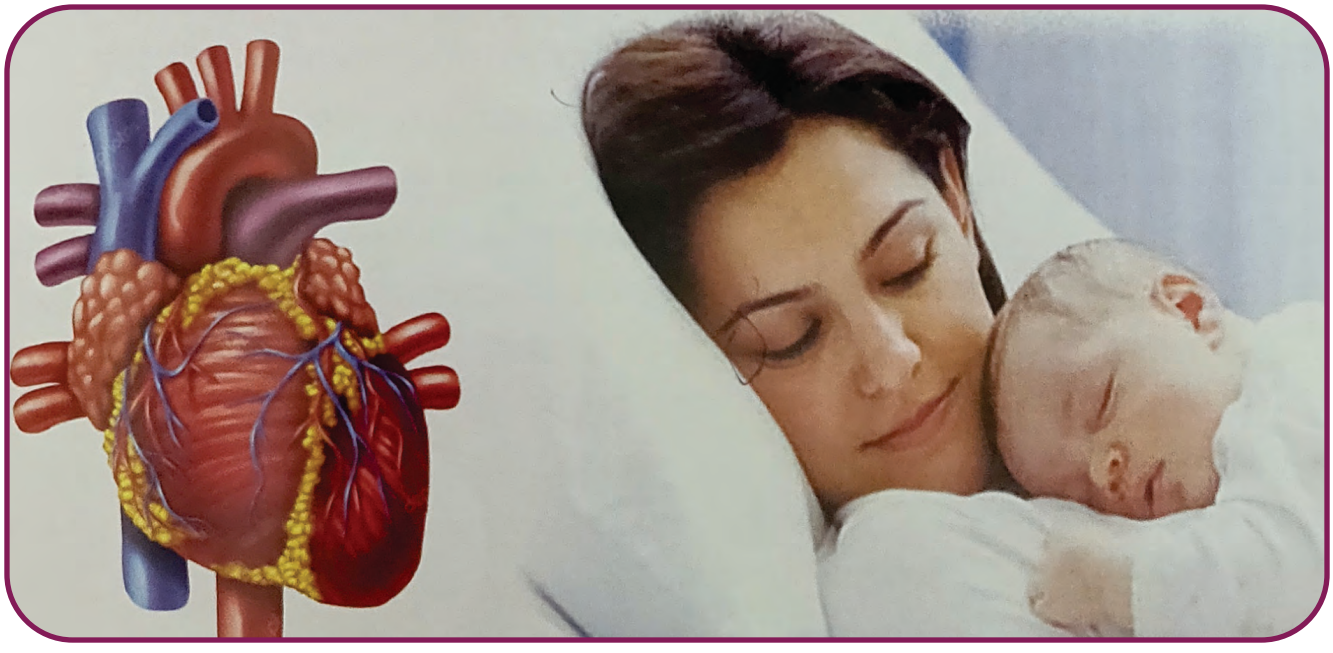

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