April 1, 2025
Volume 2, Issue 2

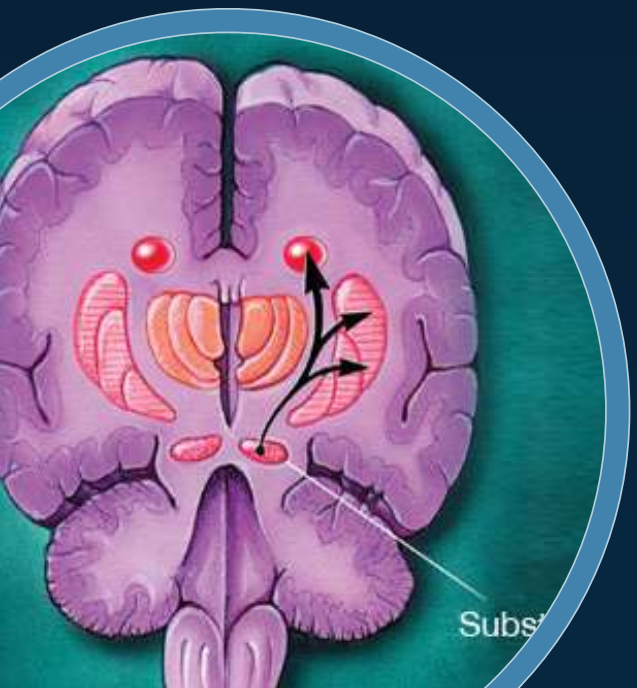
SILVER LINING

GERIATRIC MEDICINE NEWSLETTER

HIGHLIGHTS

WORLD PARKINSONS DAY APRIL 11

"A COMMUNITY FINDING THEIR LIGHT"



Read more

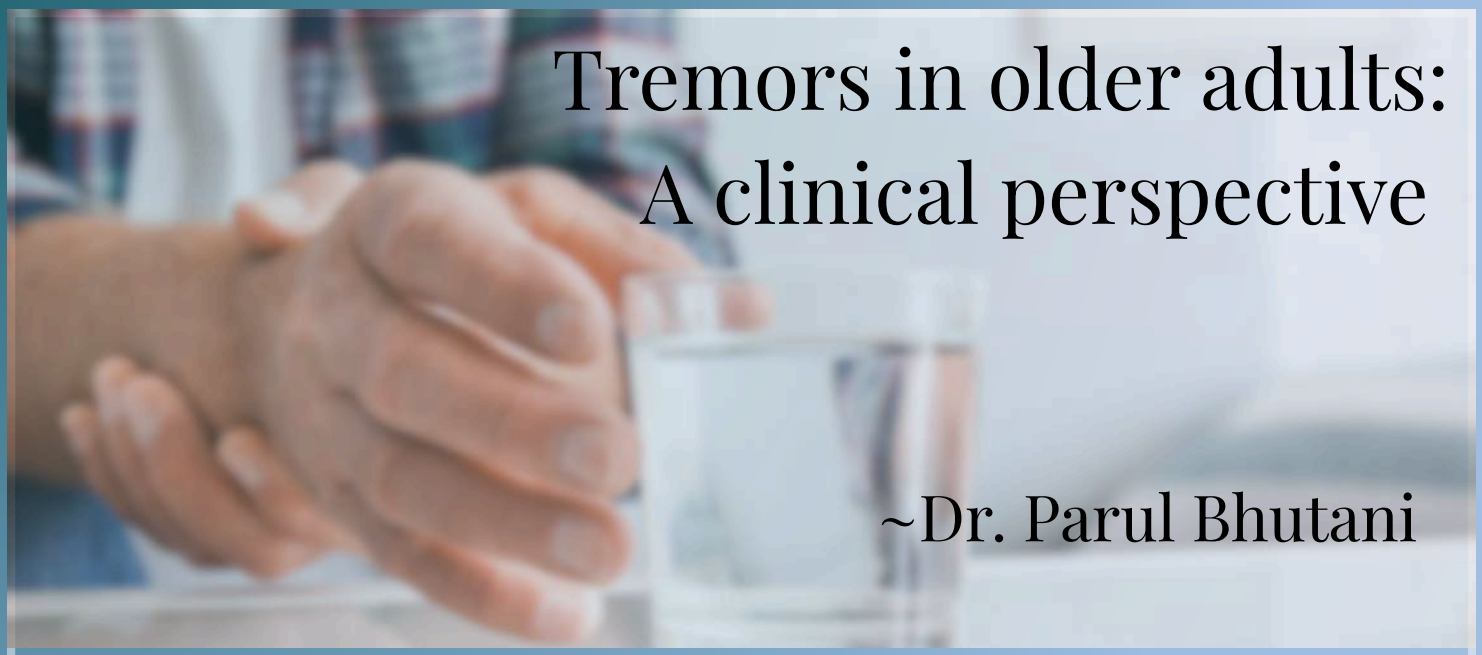
From Editors desk

~ Dr. Monika Pathania

When nature shakes the humans to pause ...

On World Parkinson's Day , 11 April , the newsletter highlights clinical ,diagnostic and management perspectives of the Parkinsons Disease (PD). Prevalence rates of PD vary from 15-45 per 100000 population with India showing a trend towards early onset motor symptoms at an early age that's a decade younger than the global average of disease onset. The disease is more than just tremors and stiffness, it encompasses disruption of daily activities, stress, anxiety of patient as well as caregivers burden, malnutrition and other related complications. Though the awareness about the disease is increasing yet the disease is underdiagnosed. The disease being multifaceted, needs a comprehensive multidisciplinary care. Advancements in research and treatment options are critical, there is need to look into the best from all the systems, conventional drugs like levodopa, carbidopa are well researched. Along with newer pharmacotherapeutic strategies, there is upcoming evidence and research on phytochemicals like Withania somnifera(ashwagandha) and Bacopa Linn (Brahmi). The newsletter reflects on clinical perspectives, newer therapies and a will to prioritise managing symptoms and improve the quality of life of patients living with PD. Lets show solidarity to the patients with Parkinsons Disease that not only shakes the lives of patients but also their caregivers .

CONTENTS



Tremors in older adults: A clinical perspective

~Dr. Parul Bhutani

Aging brings a myriad of changes, and among them, tremors are one of the most common yet often misunderstood movement disorders seen in older adults. Whether subtle or pronounced, these involuntary, rhythmic movements can significantly impact daily activities, diminishing quality of life. While tremors may be dismissed as a benign sign of aging, they often serve as an early clue to underlying neurological conditions such as Parkinson's disease, essential tremor (ET), or even metabolic disturbances. As clinicians, recognizing and classifying these tremors accurately is crucial for guiding appropriate management and improving patient outcomes.

Essential tremor (ET), one of the most frequently encountered movement disorders in the elderly, presents as a progressive action tremor affecting the hands, head, or voice. The recently introduced category of ET Plus has sparked debate in the medical community, encompassing patients with additional neurological signs such as mild dystonia, impaired gait, or cognitive decline. **Distinguishing ET from Parkinsonian tremors** is vital, as the latter predominantly occurs at rest and is often asymmetric, with associated bradykinesia and rigidity. Another distinct form, **Holmes tremor**, characterized by slow, high-amplitude movements, often points to structural brain lesions, while **neuropathic tremors** arise from peripheral nerve dysfunction. Furthermore, clinicians must remain vigilant for drug-induced tremors, commonly triggered by medications such as lithium, valproate, or certain neuroleptics.

Diagnosing tremors requires a keen eye and a structured approach. Observing tremor patterns at rest, during posture holding, and with voluntary movements can provide significant diagnostic clues. Electromyography (EMG) and accelerometry offer objective confirmation, while neuroimaging, particularly MRI, helps rule out structural causes. In familial cases, genetic testing may reveal hereditary links, particularly in conditions like spinocerebellar ataxias or Fragile-X Tremor Ataxia Syndrome (FXTAS). Beyond the neurological sphere, metabolic conditions such as hyperthyroidism can also manifest with tremors, necessitating a broad differential diagnosis.

Treatment options for tremors vary depending on the underlying cause. Essential tremor often responds well to beta-blockers like propranolol or anticonvulsants such as primidone, while Parkinsonian tremors improve with dopaminergic therapy. For patients with disabling focal tremors, botulinum toxin injections can provide targeted relief, especially in head or voice tremors.

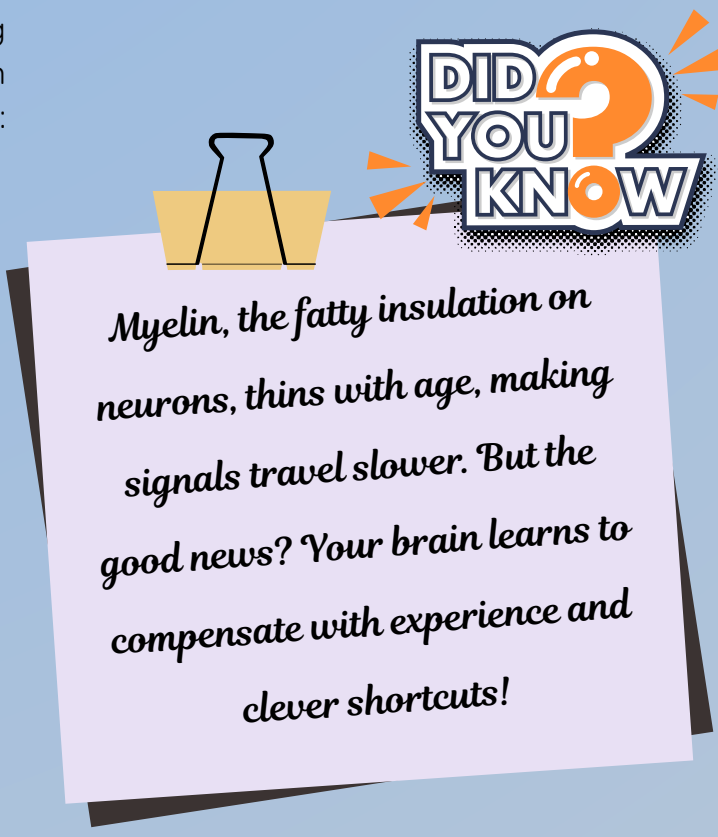
Deep brain stimulation (DBS) remains a game-changer for refractory cases, offering long-term control when medications fail. Complementary strategies, including physical therapy, occupational therapy, and lifestyle modifications, play an essential role in maintaining independence and function.

As the global population ages, tremors will become an increasingly prevalent concern in clinical practice. Understanding their classification, causes, and treatment options allows for timely interventions and improved patient care. While much progress has been made, the evolving classification of tremor disorders, particularly the debate surrounding ET Plus, highlights the need for further research into pathophysiology and biomarkers. With continued advancements, the goal remains clear: to offer patients a steadying hand amid the uncertainties of age-related tremors.

References:

Lenka A, Jankovic J. Tremor Syndromes: An Updated Review. Front Neurol. 2021;12:684835. doi: 10.3389/fneur.2021.684835.

Crawford P, Zimmerman EE. Tremor: Sorting Through the Differential Diagnosis. Am Fam Physician. 2018 Feb 1;97(3):180-186. PMID: 29431985.



Motor fluctuations in Advanced Parkinson's Disease: new horizons in therapeutic strategies

~ Dr. Kritartha Kashyap

Introduction

Parkinson's disease (PD) is a progressive neurodegenerative disorder characterized by motor symptoms such as bradykinesia, rigidity, tremor, and postural instability. The mainstay of treatment for PD is levodopa, often combined with carbidopa, which helps mitigate motor symptoms by replenishing dopamine levels in the brain. However, as the disease advances, many patients experience motor fluctuations, where the efficacy of levodopa becomes inconsistent, leading to periods of "On" time (when symptoms are well-controlled) and "Off" time (when symptoms return). These motor fluctuations in PD arise due to the progressive loss of dopaminergic neurons and the pharmacokinetic limitations of oral levodopa. These fluctuations include wearing-off phenomena, where levodopa's effect diminishes before the next scheduled dose, and dyskinesias, involuntary movements that often accompany prolonged levodopa therapy. Advanced PD patients require more frequent dosing, which increases the risk of unpredictable "Off" periods and worsens their quality of life. Managing these fluctuations has been a significant challenge in PD therapy, necessitating the development of newer treatment modalities, including and other device-assisted therapies.

In recent times, there have been various trials on lesioning therapies, newer drug delivery modalities to mitigate the effects of motor fluctuations in Advanced PD. Some of them are summarised below.

Device assisted treatments are becoming more popular in the treatment of Advanced PD. **Deep Brain Stimulation (DBS)** is a surgical treatment for Parkinson's disease that involves implanting electrodes in specific brain regions, such as the subthalamic nucleus (STN) or globus pallidus interna (GPi). These electrodes deliver electrical impulses to modulate abnormal neural activity that contributes to motor symptoms. By doing so, DBS helps smooth out motor fluctuations, reducing tremors, rigidity, and bradykinesia. DBS is **particularly effective in patients with advanced PD who experience significant "Off" periods and dyskinesias** despite optimal medication, and in those without cognitive impairment or history of psychiatric disorders. Although it carries certain risks such as infection, bleeding, or hardware complications, DBS remains one of the most effective long-term interventions for managing motor complications in PD.

LCIG (Levodopa-Carbidopa Intestinal Gel) is a therapy for Parkinson's disease where a continuous infusion of levodopa-carbidopa is delivered directly into the small intestine through a surgically placed tube. This method bypasses erratic gastric absorption, providing steady drug levels and reducing motor fluctuations. However, surgical risks, daily maintenance, and tube-related complications (such as infections or blockages) are potential drawbacks. Despite these challenges, LCIG is highly effective in managing advanced PD symptoms when oral medications become insufficient.

One of the recently US-FDA approved therapeutic modality is **Continuous Subcutaneous Apomorphine Infusion (CSAI)**, which is a dopamine agonist therapy used in advanced Parkinson's disease (PD) to manage motor fluctuations when oral medications become ineffective. It involves delivering a steady dose of apomorphine via a portable infusion pump, which **helps smooth out "On" and "Off" periods by maintaining consistent dopamine receptor stimulation**. It acts directly on dopamine receptors without requiring conversion in the brain. This makes it useful for rapid symptom relief, especially for unpredictable "Off" episodes. However, CSAI has drawbacks, including infusion-site reactions, skin nodules, and potential nausea, which often require pre-treatment with antiemetics. Despite these challenges, **CSAI offers a non-surgical alternative to deep brain stimulation (DBS) and levodopa infusions for patients with severe motor fluctuations.**

Foslevodopa/foscarbidopa (LDp/CDp) is a novel continuous subcutaneous infusion therapy that provides stable levodopa levels, reducing motor fluctuations in advanced Parkinson's disease. Compared to oral levodopa, it ensures more consistent symptom control with less "Off" time and dyskinesia. LDp/CDp consists of prodrugs of levodopa and carbidopa, which are converted into their active forms via enzymatic reactions. The continuous 24-hour subcutaneous infusion bypasses the gastrointestinal tract, eliminating variability in drug absorption. A pharmacokinetic study comparing LDp/CDp infusion with levodopa-carbidopa intestinal gel (LCIG) showed that LDp/CDp maintains equivalent levodopa exposure with less fluctuation and provides sustained symptom relief, particularly during nighttime hours.

MRI-guided Focused Ultrasound (FUS) is an innovative, non-invasive procedure used to treat motor symptoms in Parkinson's disease (PD). Unlike traditional surgical methods, FUS uses high-frequency ultrasound waves to create precise, targeted brain lesions in areas responsible for motor dysfunction, such as the globus pallidus interna (GPi) or subthalamic nucleus (STN). Studies have shown that FUS pallidotomy is particularly effective in reducing dyskinesia and motor impairment in patients with advanced PD. This technique helps alleviate symptoms by interrupting abnormal neuronal circuits involved in PD, leading to improved motor

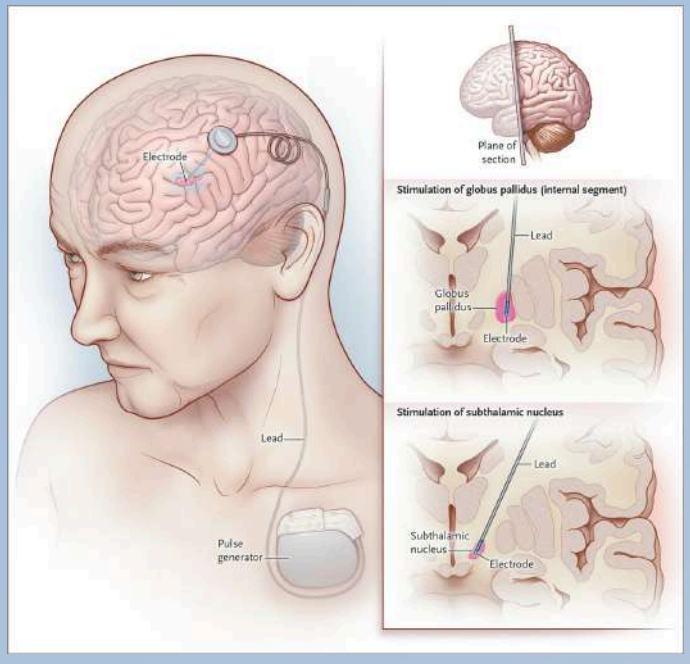


Figure: Deep-Brain Stimulation Surgery (courtesy: NEJM.org)

control. **The technique is generally used for patients with unilateral motor symptoms,** as bilateral lesioning may lead to side effects like speech or cognitive impairments. Because of its minimally invasive nature, it significantly reduces risks associated with open surgery, such as infections or complications from anesthesia. Additionally, the procedure is performed in real-time under MRI guidance, allowing precise targeting of brain structures with minimal damage to surrounding tissues.

Other surgical approaches include **Conventional Thalamotomy and Pallidotomy, Subthalamotomy for Asymmetrical PD.**

Conclusion

Motor fluctuations remain a major challenge in managing advanced Parkinson's disease. Newer therapies like foslevodopa/foscarbidopa subcutaneous infusion offer continuous dopaminergic stimulation, reducing fluctuations and improving patient quality of life. Compared to LCIG and DBS, LDp/CDp provides a non-surgical, convenient alternative with similar efficacy. Lesioning procedures, particularly MRI-guided focused ultrasound, offer additional options for select patients. As research continues, further refinements in therapy delivery and individualized approaches will enhance outcomes for PD patients.

References:

1. Ahlskog JE, Muenter MD. Frequency of levodopa-related dyskinesias and motor fluctuations as estimated from the cumulative literature. Mov Disord 2001; 16:448.
2. Williams DR, Evans AH, Fung VSC, et al. Practical approaches to commencing device-assisted therapies for Parkinson disease in Australia. Intern Med J 2017; 47:1107.
3. Weaver FM, Follett K, Stern M, et al. Bilateral deep brain stimulation vs best medical therapy for patients with advanced Parkinson disease: a randomized controlled trial. JAMA 2009; 301:63.
4. Vitek JL, Jain R, Chen L, et al. Subthalamic nucleus deep brain stimulation with a multiple independent constant current-controlled device in Parkinson's disease (INTREPID): a multicentre, double-blind, randomised, sham-controlled study. Lancet Neurol 2020; 19:491.
5. Olanow CW, Kieburtz K, Odin P, et al. Continuous intrajejunal infusion of levodopa-carbidopa intestinal gel for patients with advanced Parkinson's disease: a randomised, controlled, double-blind, double-dummy study. Lancet Neurol 2014; 13:141.
6. Deuschl G, Antonini A, Costa J, et al. European Academy of Neurology/Movement Disorder Society-European Section Guideline on the Treatment of Parkinson's Disease: I. Invasive Therapies. Mov Disord 2022; 37:1360.
7. Hallett M, Litvan I. Evaluation of surgery for Parkinson's disease: a report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology. The Task Force on Surgery for Parkinson's Disease. Neurology 1999; 53:1910.
8. Rosebraugh M, Stodtmann S, Liu W, Facheris MF. Foslevodopa/foscarbidopa subcutaneous infusion maintains equivalent levodopa exposure to levodopa-carbidopa intestinal gel delivered to the jejunum. Parkinsonism Relat Disord. 2022 Apr;97:68-72. doi: 10.1016/j.parkreldis.2022.03.012.
9. Fung VSC, Aldred J, Arroyo MP, Bergquist F, Boon AJW, Bouchard M, Bray S, Dhanani S, Facheris MF, Fisseha N, Freire-Alvarez E, Hauser RA, Jeong A, Jia J, Kukreja P, Soileau MJ, Spiegel AM, Talapala S, Tarakad A, Urrea-Mendoza E, Zamudio J, Pahwa R. Continuous subcutaneous foslevodopa/foscarbidopa infusion for the treatment of motor fluctuations in Parkinson's disease: Considerations for initiation and maintenance. Clin Park Relat Disord. 2024 Feb 10;10:100239. doi: 10.1016/j.prdoa.2024.100239.

FUN FACT

Also known as Bacopa monnieri, Brahmi is like a personal trainer for your neurons! It helps boost memory, focus, and neuroprotection, and may even slow Neuro degeneration, making it a natural choice for brain health! So, start eating your greens!

Clinical case vignette

~ Dr. Pankhuri Saxena

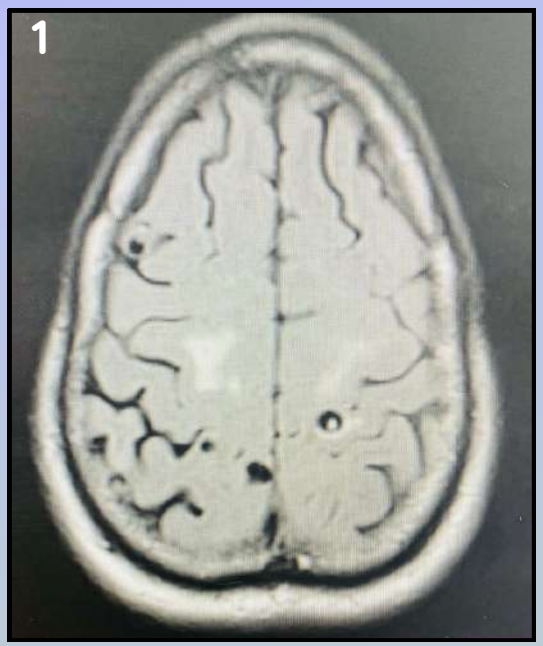
Mr. X, a 72-years-old gentleman, retired accountant presented to the cognitive clinic with a two-years history of progressive decline in his memory. Initially, he experienced mild forgetfulness and difficulty in multitasking, which gradually worsened, associated with episodes of confusion, especially in the evenings. His family reported he had also started seeing "things" around the house which were not really there, and it had become more frequent recently. Although according to his wife, there were periods of lucidity in between these episodes. She further added that there were nights, when she woke up from sleep to find her husband loudly screaming or fidgeting around in his sleep. Over the past year, he became slow in his daily activities and started experiencing frequent episodes of falls.

On examination, he was alert but restless. He scored a total 50 scores in ACE-III, with predominant memory and visuospatial impairment. Cranial nerve examination was unremarkable. Motor examination revealed bradykinesia, rigidity (more pronounced on the right side), and a stooped posture. His gait was slow and shuffling. Deep tendon reflexes were normal, and the plantar response was flexor.

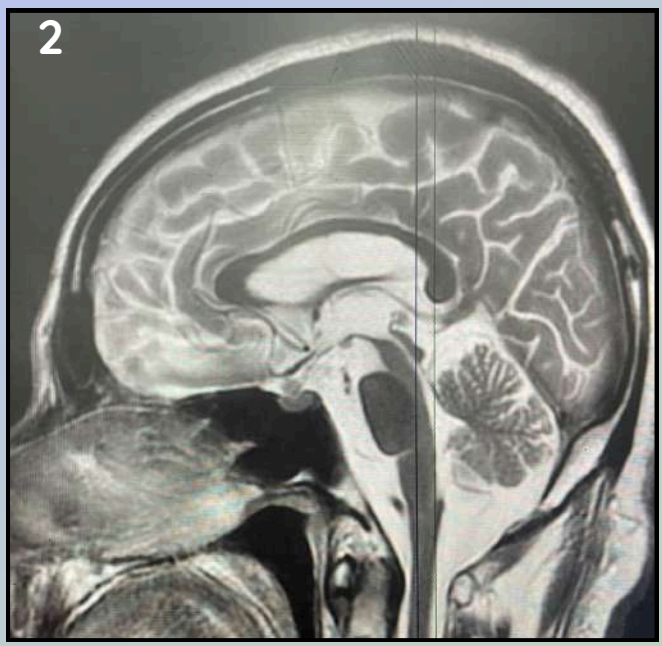
1. What is his most likely clinical diagnosis?
2. Define the core diagnostic criteria for this condition?

Clinical images

~ Dr. SurjitKumar Singh



A) What is the finding ?
B) What is the treatment of the condition?



A) What is the finding ?
B) Which type of proteinopathy is this ?

Answers for last Issue

~ Compiled by Dr. Nikhil Choudhary
Dr. Arun Shankar

The clinical presentation suggests **Infective Endocarditis (IE)** in a patient with a history of rheumatic heart disease (which predisposes him to valvular pathology). The presence of low-grade fever, fatigue, weight loss, progressive dyspnea, bilateral lower limb swelling, and embolic phenomena (splinter hemorrhages, petechiae) along with a loud diastolic murmur (suggesting aortic regurgitation) and positive blood cultures for Streptococcus viridans strongly supports this diagnosis.

Table 34.3. The Modified Duke Criteria for the Diagnosis of Endocarditis

Major Criteria

- Blood culture positive for IE
  - Typical microorganisms consistent with IE from two separate blood cultures
    - Viridans streptococci; *Streptococcus bovis*, HACEK group, *Staphylococcus aureus*; or
    - Community-acquired enterococci, in the absence of a primary focus
  - Microorganisms consistent with IE from persistently positive blood cultures, defined as follows:
    - At least two positive blood cultures of blood samples drawn >12 h apart; or
    - All of three or a majority of ≥4 separate cultures of blood (with first and last sample drawn at least 1 h apart)
  - Single positive blood culture for *Coxiella burnetii* or antiphase I IgG antibody titer >1:800
- Evidence of endocardial involvement
- Echocardiogram positive for IE (TEE recommended in patients with prosthetic valves, rated at least "possible IE" by clinical criteria, or complicated IE [paravalvular abscess]; TTE as first test in other patients), defined as follows:
  - Oscillating intracardiac mass on valve or supporting structures, in the path of regurgitant jets, or on implanted material in the absence of an alternative anatomic explanation; or
  - Abscess; or
  - New partial dehiscence of prosthetic valve
- New valvular regurgitation (worsening or changing or preexisting murmur not sufficient)

Minor Criteria

- Predisposition, predisposing heart condition or injection drug use
- Fever, temperature >38°C
- Vascular phenomena, major arterial emboli, septic pulmonary infarcts, mycotic aneurysm, intracranial hemorrhage, conjunctival hemorrhages, and Janeway lesions
- Immunologic phenomena: Glomerulonephritis, Osler nodes, Roth's spots, and rheumatoid factor
- Microbiological evidence: Positive blood culture but does not meet a major criterion as noted previously (excluding single positive cultures for coagulase-negative staphylococci and organisms that do not cause endocarditis) or serologic evidence of active infection with organisms consistent with IE
- Echocardiographic minor criteria eliminated

IE, Infective endocarditis; *TEE*, transesophageal echocardiography; *TTE*, transthoracic echocardiography.
Modified from Li, J. S., Sexton, D. J., Mick, N., Nettles, R., Fowler, V. G., Ryan, T., et al. (2000). Proposed modifications to the Duke criteria for the diagnosis of infective endocarditis. Clinical Infectious Diseases, 30(4), 633–638.

Table 34.2. The Modified Duke Criteria Definitions of Definite, Possible, and Rejected Endocarditis

Definite IE

- Pathologic criteria
  1. Microorganisms demonstrated by culture or histologic examination of a vegetation, a vegetation that has embolized, or an intracardiac abscess specimen; or
  2. Pathologic lesions; vegetation or intracardiac abscess confirmed by histologic examination showing active endocarditis
- Clinical criteria (see Table 34.3)
  1. Two major criteria
  2. One major criterion and three minor criteria
  3. Five minor criteria

Possible IE (see Table 34.3)

1. One major criterion and one minor criterion
2. Three minor criteria

Rejected

1. Firm alternate diagnosis explaining evidence of IE
2. Resolution of infection endocarditis syndrome with antibiotic therapy for ≤4 days
3. No pathologic evidence of IE at surgery or autopsy, with antibiotic therapy for ≤4 days
4. Does not meet criteria for possible IE, as described previously

IE, Infective endocarditis.
Modified from Li, J. S., Sexton, D. J., Mick, N., Nettles, R., Fowler, V. G., Ryan, T., et al. (2000). Proposed modifications to the Duke criteria for the diagnosis of infective endocarditis. Clinical Infectious Diseases, 30(4), 633–638.

Answer was given by
Dr. P. Aravind Babu, MD Geriatrics
Assistant Professor
Department of Geriatrics
Virudhunagar, Tamil Nadu

TABLE 128-5 Antibiotic Treatment for Infective Endocarditis Caused by Common Organisms[a]

ORGANISM(S)	DRUG (DOSE, DURATION)	COMMENTS
Streptococci		**For PVE 6-week regimens are preferred.**
Penicillin-susceptible streptococci, *S. gallolyticus* (MIC ≤0.12 μg/mL[b])	• Penicillin G (2–3 mU IV q4h for 4 weeks)	Can use ampicillin or amoxicillin (2 g IV q4h) if penicillin is unavailable.
	• Ceftriaxone (2 g daily as a single dose for 4 weeks)	Can use ceftriaxone in patients with non-immediate penicillin allergy.
	• Vancomycin[c] (15 mg/kg IV q12h for 4 weeks)	Use vancomycin for patients with immediate (urticarial) or severe penicillin allergy. Obtain allergy consultation for further evaluation including role of β-lactam desensitization.
	• Penicillin G (2–3 mU IV q4h) *or* ceftriaxone (2 g IV daily) for 2 weeks ***plus*** Gentamicin[d] (3 mg/kg daily IV or IM, as a single dose[e] or divided into equal doses q8h for 2 weeks)	Avoid 2-week regimen when risk of aminoglycoside toxicity is increased and in prosthetic-valve or complicated endocarditis. Can use ampicillin or amoxicillin (2 g IV q4h) if penicillin is unavailable.
Relatively penicillin-resistant streptococci, *S. gallolyticus* (MIC >0.12 μg/mL and <0.5 μg/mL[f])	• Penicillin G (4 mU IV q4h) *or* ceftriaxone (2 g IV daily) for 4 weeks ***plus*** Gentamicin[d] (3 mg/kg daily IV or IM, as a single dose[e] or divided into equal doses q8h for 2 weeks)	Can use ampicillin or amoxicillin (2 g IV q4h) if penicillin is unavailable. Penicillin alone at this dose for 6 weeks or with gentamicin during the initial 2 weeks is preferred for PVE caused by streptococci with penicillin MICs of ≤0.12 μg/mL.
	• Vancomycin[c] as noted above for 6 weeks	Use vancomycin for patients with immediate (urticarial) or severe penicillin allergy. Obtain allergy consultation for further evaluation including role of β-lactam desensitization. Ceftriaxone alone or with gentamicin can be used in patients with non-immediate β-lactam allergy.
Moderately penicillin-resistant streptococci (MIC, ≥0.5 μg/mL and <8 μg/mL[g]); *Granulicatella*, *Abiotrophia*, or *Gemella* spp.	• Penicillin G (4–5 mU IV q4h) *or* ceftriaxone (2 g IV daily) for 6 weeks ***plus*** Gentamicin[d] (3 mg/kg daily IV or IM as a single dose[e] *or* divided into equal doses q8h for 6 weeks)	Preferred for PVE caused by streptococci with penicillin MICs of >0.12 μg/mL. Can use ampicillin or amoxicillin (2 g IV q4h) if penicillin is unavailable.
	• Vancomycin[c] as noted above for 6 weeks	Regimen is preferred by some

Source: Harrisons Principle of Internal Medicine, 21st Edition

Clinical Images answers

1.

A) Cardiac tamponade

B) Becks triad - Hypotension, Elevated JVP, Muffled heart sounds

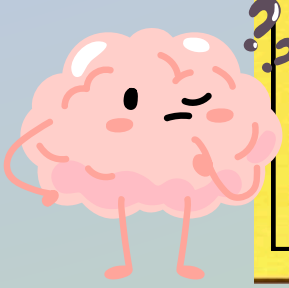
2.

A) Fish mouth appearance of Mitral valve

B) Rheumatic heart disease - Mitral Stenosis

Parkinsons is **MORE THAN JUST** typical motor symptoms.
The non-motor symptoms can help in early detection of this condition.

- Your **NOSE** knows.....Anosmia !!
- **GUT FEELINGS** ?? Trust it!.....Constipation
- **DREAMS** can really get scary!...REM sleep behavioural disorder
- **BRAIN FOGGING** is real!...Bradyphrenia or slowed processing
- The **TINY HANDWRITING** mystery !!....Micrographia
- **MOOD SWINGS** are true!....Depression and Anxiety
- The **ICE EFFECT** ?? Yes.....Hypomimia
- **GETTING DIZZY** !!!.....Orthostatic Hypotension

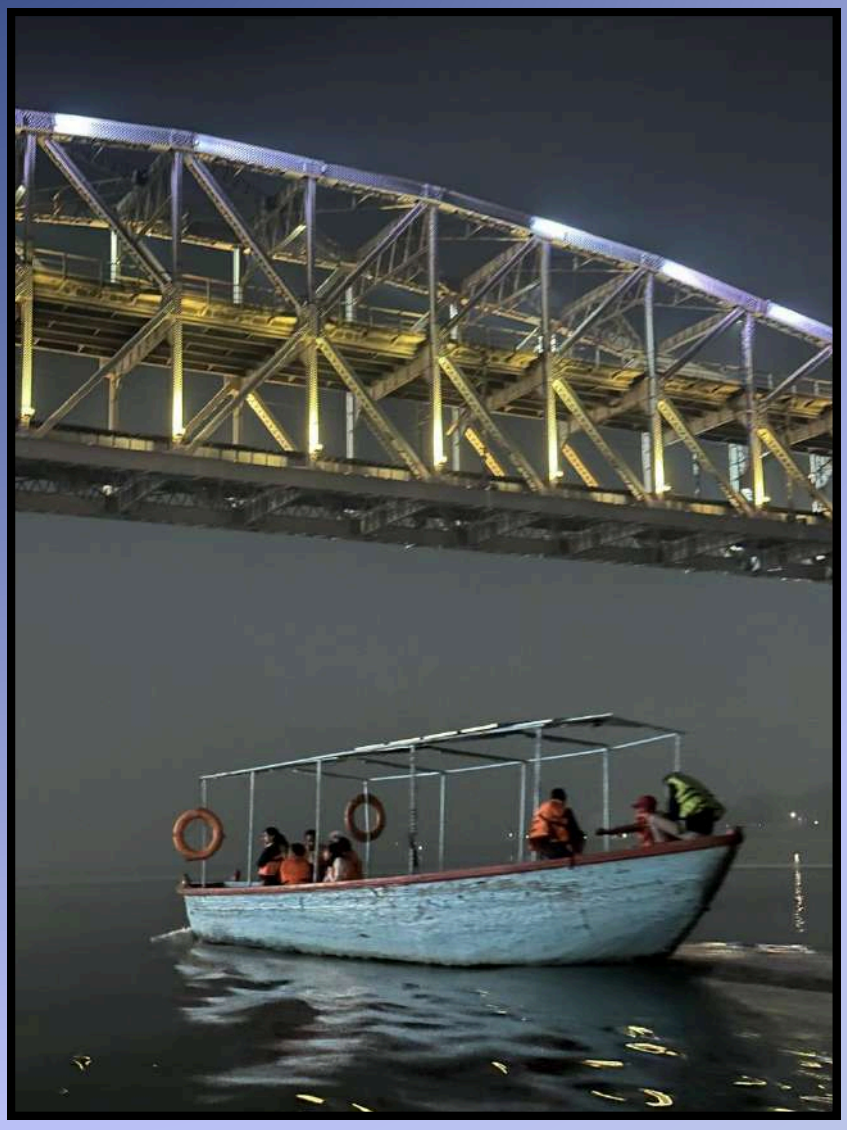


Pandemonium

~ Dr. Kritartha Kashyap

"How have you been?"
A question that people have been asking since the last two years.
My lips part and a familiar line comes out,
almost immediately,
"It's getting better, Thanks.";
followed by a nod and a hint of a smile.
Almost automated, rehearsed.
My eyes dart back to the table,
A puddle of freshly prepared tea
Clear enough to see my own reflection there,
grey, wrinkled, with eyes I don't recognise myself.
I stare at its pupil, dark, hollow
and it slowly shape shifts into a saucer,
another me trying to pick it up.
"Don't!!!....." I make almost a muffled cry.
Too late! I watch as a 8.2 richter quake jolts my body.
The saucer shattering into pieces;
sharp enough to cut through the silence of the room.
Tearing through the open door,
that's been waiting forever for the return of a memory.
I look through it, another me,
Trying to get on my coat. For what ?
Probably the funeral of my memories!
The world suddenly slows down;
And I get pulled back,
Like a million hands tugging at my back.
Why is there no one to help me?
The world spins and wham!!!
"Papa!!!" I suddenly wake up to the familiar face, concerned.
"He asked you how you've been?"
And I hear the crisp scribbling of a pen go....
"Let us try increasing the dose."
Another voice goes.
Maybe he's right! Because in reality,
I haven't really been well.

FLASHLIGHT



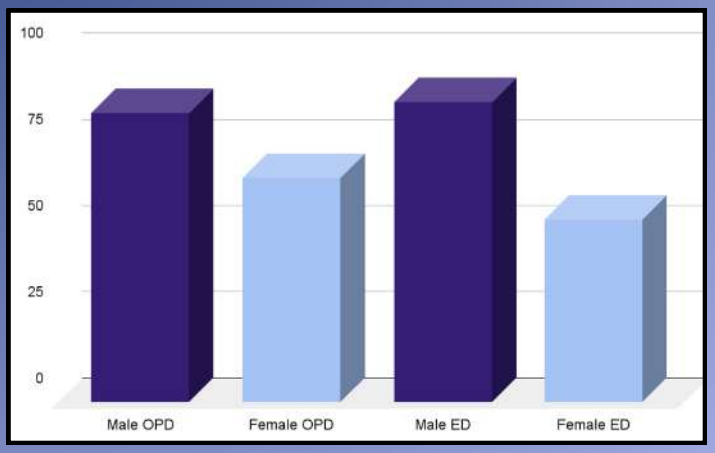
~Contributed by
Dr. Dipesh Jha

Dr. US Sai Sachin receiving third position in World TB Day Quiz held by Deptt of Pulmonary Medicine

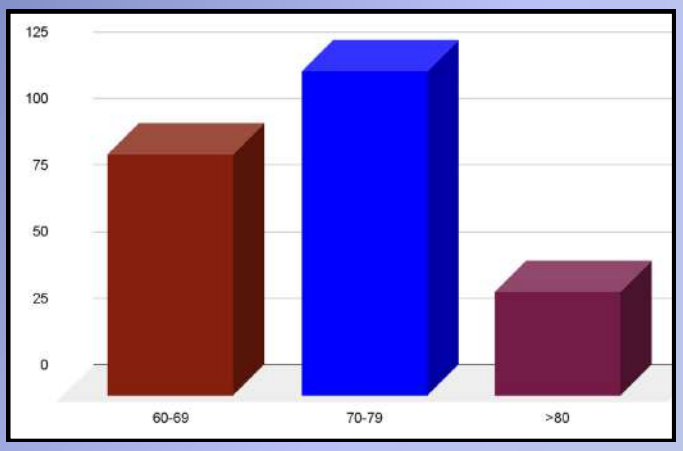
Got a knack for photography ?
Then hurry up and send in your submissions to
silverliningsaiimsrishikesh@gmail.com

DEPARTMENT STATISTICS

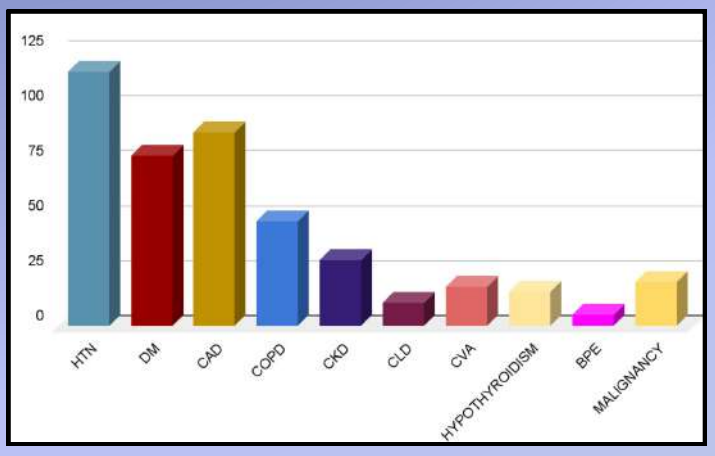
January - March



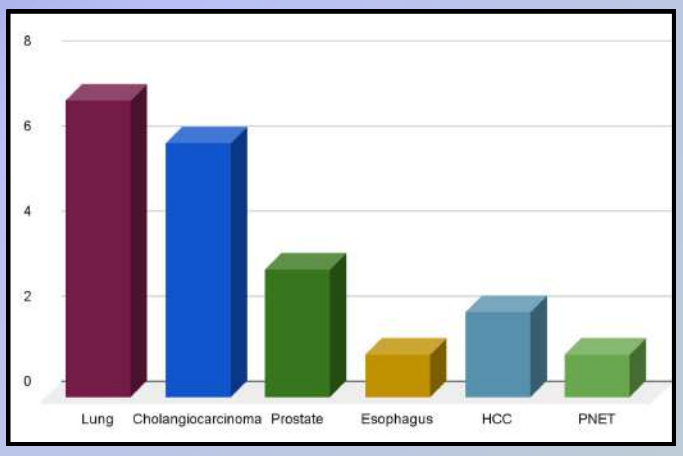
Gender wise distribution



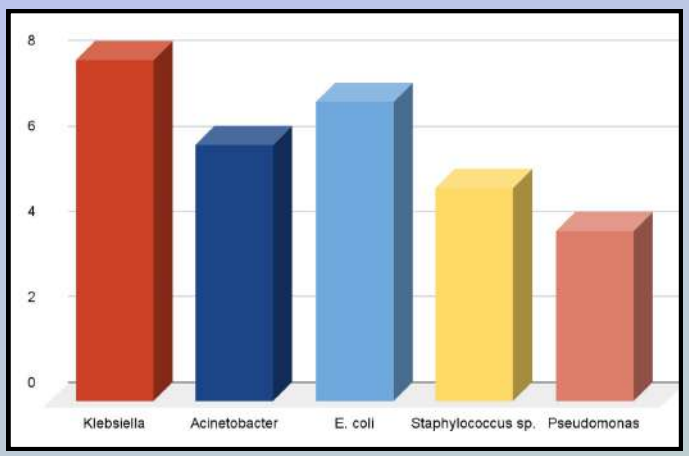
Age category wise distribution



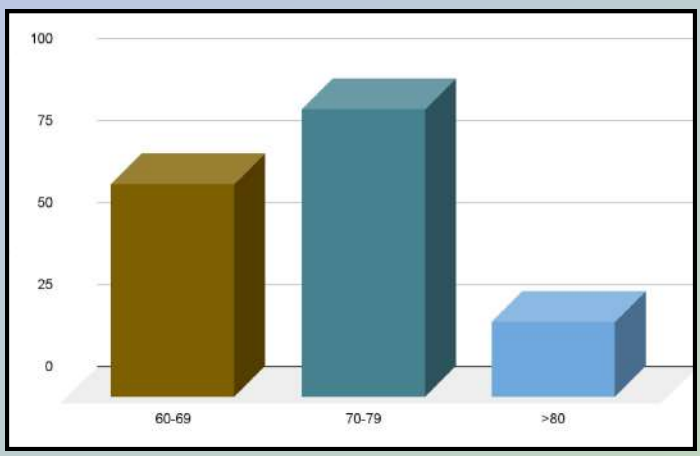
Co-morbidities distribution



Distribution of Malignancies



MDR organisms isolated



Patients discharged succesfully

PHOTO GALLERY

Snippets from 2nd Annual anniversary celebration of the Department!!

"Still miles to go...."

"Yaadein sath reh jaati hain..." **We bid adieu to few, with a promise to meet again**

Dr. Sudeep Mathew George, Senior Resident

Dr. Tabassum Firdaus, Junior Resident

Mrs. Anita Gaira, Ms. Pragati Negi, Nursing Officers

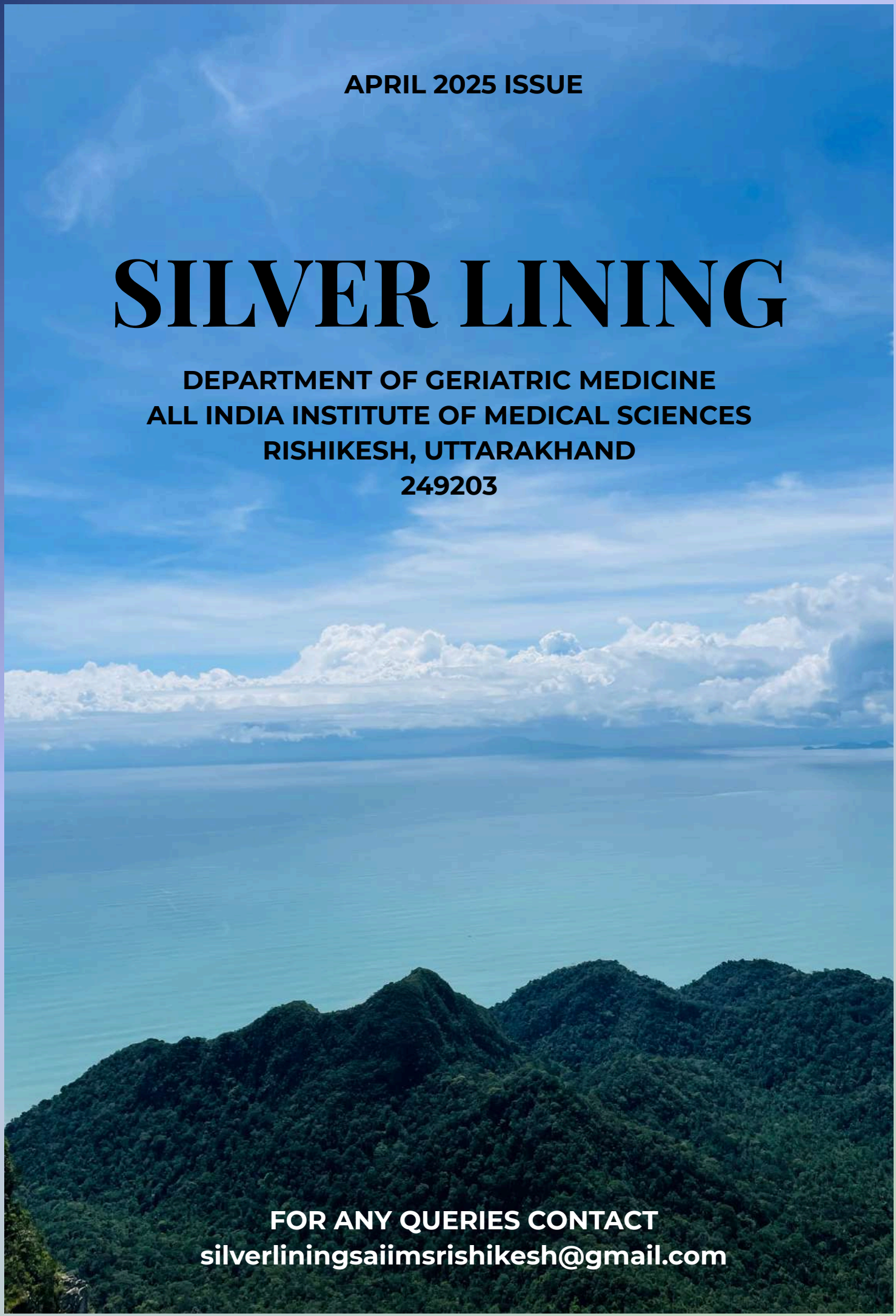
SEND IN YOUR SUBMISSIONS

If you know the answers to the above asked questions, kindly mail us your answers with your name and department. Correct answers win a SHOUT-OUT on subsequent issues of the newsletter.

If you don't know the answers, well wait for it in the next issue. Do you have a talent for writing, whether it's in scientific or creative fields ? Show off your skills in our newsletter! We're accepting submissions for Creative sections. Send us your essays, stories, memoirs, poetry, prose or artwork at **silverliningsaiimsrishikesh@gmail.com**

We hope you've enjoyed this edition of "SILVER LINING". We value your feedback and would love to hear about your experience. Contact us for any queries or feedback at **silverliningsaiimsrishikesh@gmail.com**

Our next issue is going to be released on July 1st. That's right!! On "Doctor's Day". We heartily welcome any kind of creative or scientific entries, personal experiences on this occasion. So hurry up and send in your submissions on or before June 1st. Show your talent through our newsletter.
Happy Reading !!



APRIL 2025 ISSUE

SILVER LINING

DEPARTMENT OF GERIATRIC MEDICINE
ALL INDIA INSTITUTE OF MEDICAL SCIENCES
RISHIKESH, UTTARAKHAND
249203

FOR ANY QUERIES CONTACT
silverliningsaiimsrishikesh@gmail.com