JULY 1, 2025
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SILVER LINING

GERIATRIC MEDICINE NEWSLETTER

OSTEOPOROSIS IN ELDERLY

VITAMIN D IN OLDER ADULTS

READ MORE

The hands that heal...

~Dr. Kritartha Kashyap

Every year on July 1st, India celebrates National Doctors' Day—a tribute to the birth and legacy of Dr. B.C. Roy, a physician, freedom fighter, and statesman. It is a day to recognise the silent warriors of our healthcare system: doctors who work tirelessly across villages and cities, clinics and ICUs, often against overwhelming odds.

However, despite the reverence surrounding the medical profession, the plight of Indian doctors remains a pressing concern. Overburdened public hospitals, long hours of work, limited infrastructure and increasing violence against doctors throughout the country, make their service a test of resilience and commitment. Yet, they remain the backbone of a complex and often under-resourced healthcare system.

In this landscape, a new challenge is quietly emerging—the aging of India. With growing burden of older population, the demand for geriatricians is also growing in Indian society. Geriatric medicine is still a nascent field in India, with few trained professionals. Although it is gradually catching a momentum with new medical colleges opening postgraduate courses, there still a long way to go and a lot to work on to create awareness regarding the need of more geriatricians among public and healthcare professionals. As chronic diseases, frailty, dementia, sarcopenia, falls and several other important aspect of geriatric care are becoming prevalent and gaining interests among researchers, the role of geriatricians are crucial in ensuring dignified, comprehensive and patient centred care for the elders of our society.

We hope you'll enjoy reading our July issue where we try to shed light on one such important aspect of a geriatric health - Osteoporosis and bone health.

On this Doctors' Day, let us not only celebrate our physicians but also advocate for better working conditions, greater support, and renewed respect for the incredible service doctors provide to society.

CONTENTS

Osteoporosis in elderly : an overview

~Dr. Parul Bhutani

INTRODUCTION

Osteoporosis is a systemic skeletal disorder characterized by reduced bone mass and microarchitectural deterioration of bone tissue, leading to increased fragility and fracture risk. Osteoporotic (or fragility) fractures occur with minimal trauma, most commonly affecting the hip, vertebrae, and distal forearm. (1)

Among older adults, such fractures are a major contributor to disability, loss of independence, institutionalization, and mortality. Despite its high prevalence and consequences, osteoporosis remains underdiagnosed and undertreated, particularly in the elderly.

NON-MODIFIABLE RISK FACTORS	MODIFIABLE RISK FACTORS
Personal history of fracture as an adult	Current cigarette smoking
History of fracture in first-degree relative	Estrogen deficiency
Female gender	Poor nutrition especially low calcium and vitamin D
Advanced age	intake Alcoholism
White race	Impaired eyesight despite adequate correction
Dementia	Recurrent falls
	Inadequate physical activity
	Poor health/frailty
	Low body weight/BMI < 20 kg/m²
	Diabetes
	Rheumatoid Arthritis

Table 1: Showing Risk Factors

EPIDEMIOLOGY

The global burden of osteoporosis is substantial, affecting over 200 million individuals. In women over 50 years, one in two will experience an osteoporosis-related fracture; in men, this risk is about one in five (2). In the Indian context, the lack of awareness and limited access to screening tools further amplify the burden among aging populations.

RISK FACTORS

Osteoporosis arises from the interplay of age-related bone loss, comorbidities, and external factors. Risk factors given in table 1. Medications such as glucocorticoids, anti-epileptics, SSRIs, heparin, and proton pump inhibitors also contribute to secondary osteoporosis and must be considered during clinical evaluation [1,2].

PATHOPHYSIOLOGY

Osteoporosis results from an imbalance between bone resorption and bone formation. With advancing age, there is a decline in osteoblastic activity and a relative increase in osteoclastic bone resorption. Hormonal changes—especially estrogen deficiency in women and testosterone decline in men—alongside chronic inflammation, oxidative stress, and nutritional deficiencies contribute to accelerated bone loss [3].

APPROACH TO DIAGNOSIS

The FRAX® tool helps estimate a patient's 10-year risk of major osteoporotic and hip fractures using clinical risk factors with or without BMD values. An initial FRAX assessment can be used to identify patients at low, intermediate, high or very high risk of fracture (Strongly recommended by NOGG).

Bone mineral density (BMD) testing via DXA scan remains the gold standard for diagnosis. Indications for BMD testing include women ≥65 years, men ≥70 years, younger individuals with risk factors, and anyone with a history of fragility fractures [2]. (Table 2)

Vertebral imaging should be considered in patients with height loss, kyphosis, or back pain. Emerging bone turnover markers like P1NP and CTX may assist in treatment monitoring but are not yet widely used in routine practice [2]. (Table 3)

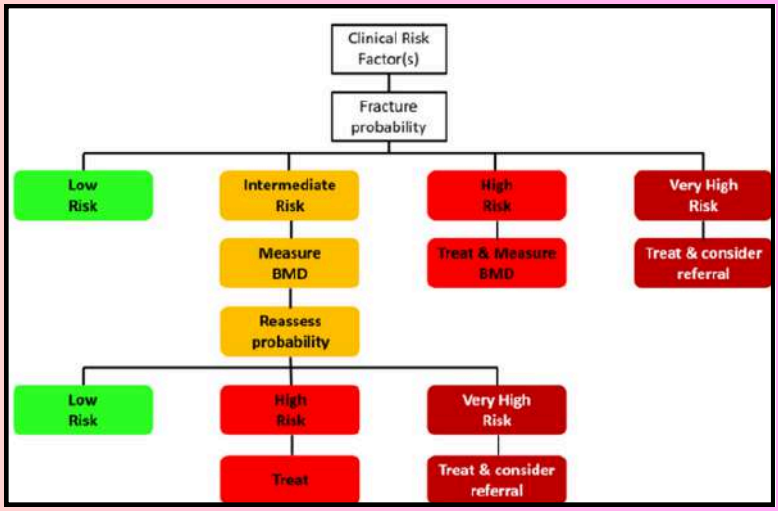

Figure 1

Indications for BMD assessment
1. Women age 65 and older and men age 70 and older, regardless of clinical risk factors
2. Younger postmenopausal women, women in the menopausal transition, and men age 50 to 69 with clinical risk factors for fracture
3. Adults who have a fracture at or after age 50
4. Adults with a condition (e.g., rheumatoid arthritis) or taking a medication (e.g., glucocorticoids in a daily dose ≥5 mg prednisone or equivalent for ≥3 months) associated with low bone mass or bone loss

Table 2

Indications for Vertebral Imaging
All women age 70 and older and all men age 80 and older if BMD T-Score at the spine, total hip, or femoral neck is ≤–1.0
Women age 65 to 69 and men age 70 to 79 if BMD T-score at the spine, total hip, or femoral neck is ≤–1.5
Postmenopausal women and men age 50 and older with specific risk factors: ▪ Low-trauma fracture during adulthood (age 50 and older) ▪ Historical height loss of 1.5 in. or more (4 cm) ▪ Prospective height loss of 0.8 in. or more (2 cm) ▪ Recent or ongoing long-term glucocorticoid treatment

Table 3

TREATMENT AND FOLLOW-UP

Pharmacologic therapy is recommended in individuals with:

- Prior hip or vertebral fracture
- T-score ≤ –2.5 on DXA
- Low bone mass (osteopenia) and a US-adapted WHO 10-year probability of a hip fracture ≥3 % or 10-year probability of any major osteoporosis-related fracture ≥20 %

Treatment options include bisphosphonates, denosumab, and anabolic agents like teriparatide or romosozumab for high-risk cases. Regular reassessment of BMD and adherence monitoring are essential for long-term fracture prevention [1,2]

Follow Up:

- Reassess fracture risk and BMD every 1-2 years
- Monitor adherence and side effects
- Re-evaluate after 3-5 years of therapy for treatment duration and drug holidays (especially for bisphosphonates) -Fig. 2

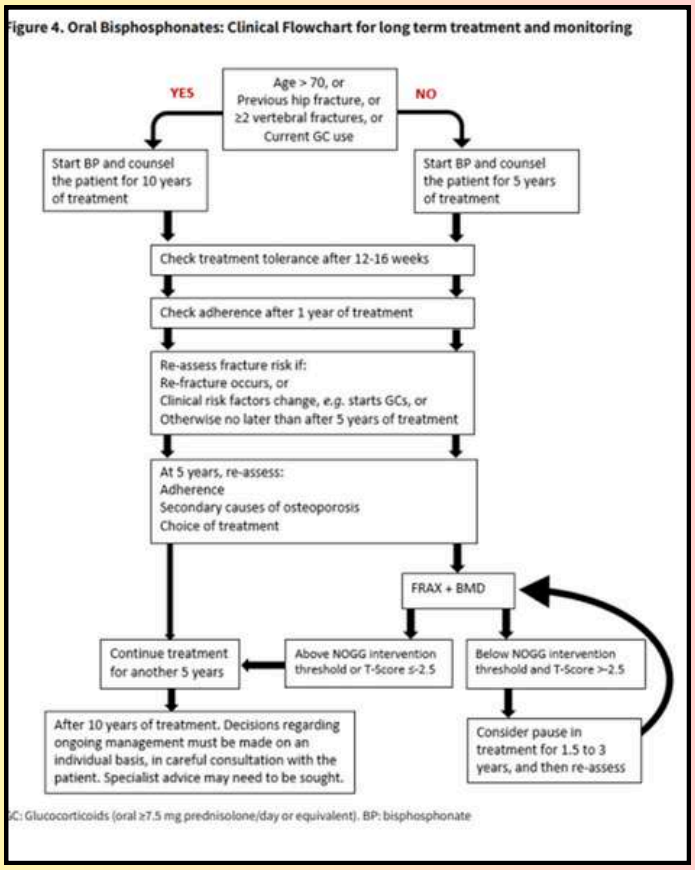

Figure 2

PREVENTION

Preventive strategies include adequate calcium (1000–1200 mg/day) and vitamin D (800–1000 IU/day) intake, regular weight-bearing exercises, fall prevention, and lifestyle modifications like quitting smoking and limiting alcohol. Geriatricians must integrate these into routine care for older adults [2].

CONCLUSION

Osteoporosis is a modifiable risk factor for significant morbidity in the elderly. Early identification, holistic risk assessment, and individualized management can preserve mobility and independence. Geriatricians play a pivotal role in ensuring this silent disease does not go unnoticed.

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Vitamin D supplementation in older adults: evidence-based insights from recent clinical trials

~ Dr. Kritartha Kashyap

Vitamin D plays a crucial role in musculoskeletal health, especially in older adults. With advancing age, the risk of vitamin D deficiency increases due to reduced skin synthesis, limited sun exposure, and dietary insufficiency. Given its central role in calcium absorption, muscle function, immune modulation, fall prevention and cellular health, vitamin D supplementation is widely recommended. For adults aged 51–70 years, the recommended dietary allowance (RDA) for vitamin D is 600 IU/day, increasing to 800 IU/day for those aged ≥70 years.(1) Many organisations suggest higher daily intake of 800–2000 IU, especially for older adults, to achieve optimal serum 25-hydroxyvitamin D [25(OH)D] levels above 30 ng/mL.(2) However, recent large-scale trials and meta-analyses have provided nuanced insights into its effectiveness in reducing fractures, falls, and cognitive decline in the elderly.

Vitamin D supplementation has long been considered a preventive strategy for fractures in older adults. However, recent large-scale randomized controlled trials challenge this assumption. The **VITAL trial**, one of the most comprehensive U.S.-based studies, involved over 25,000 participants aged 50 years and older who received 2000 IU of vitamin D_3 daily without coadministered calcium. Over a median follow-up of 5.3 years, the trial found no significant reduction in total, nonvertebral, or hip fractures compared to placebo.

These results held true across various subgroups, including those with low baseline vitamin D status, prior fragility fractures, and users of osteoporosis medication. This suggests that vitamin D supplementation alone may not be sufficient for fracture prevention in a generally healthy, community-dwelling older population in absence of deficiency or low bone mass.(3) Similar conclusions emerged from the European **DO-HEALTH trial**, which tested vitamin D_3 (2000 IU/day), omega-3 fatty acids, and strength-training exercise—alone and in combination—among over 2,000 older adults. While the trial examined a composite primary outcome that included fractures, infections, and other health metrics, none of the individual or combined interventions showed statistically significant benefit on fracture reduction. These findings reinforce the notion that vitamin D supplementation, even at higher-than-recommended doses, may not confer skeletal protection when not combined with calcium or targeted toward high-risk populations.(4)

The effect of vitamin D on fall risk in older adults has also been rigorously studied. A 2024 network meta-analysis by Tan and colleagues synthesized data from 35 randomized controlled trials involving nearly 59,000 participants. The analysis found that vitamin D supplementation in the range of 800–1000 IU per day was associated with a 15–22% reduction in fall risk, particularly among individuals with 25(OH)D levels below 50 nmol/L. Importantly, the benefit was observed only with daily dosing regimens; high-dose intermittent boluses (e.g., monthly or yearly mega-doses) were associated with an increased risk of falls. The protective effect was also more pronounced when vitamin D was combined with calcium. These findings further support the use of moderate-dose, daily vitamin D supplementation, particularly in deficient older adults, in combination with calcium as part of a fall prevention strategy.(5) In another long-term follow-up analyses, calcium plus vitamin D supplementation was found to be associated with modest benefits in hip bone mineral density and a slight reduction in hip fracture risk.(6) These results suggest that combining vitamin D with calcium may have cumulative skeletal benefits, particularly when initiated in early and maintained over time.

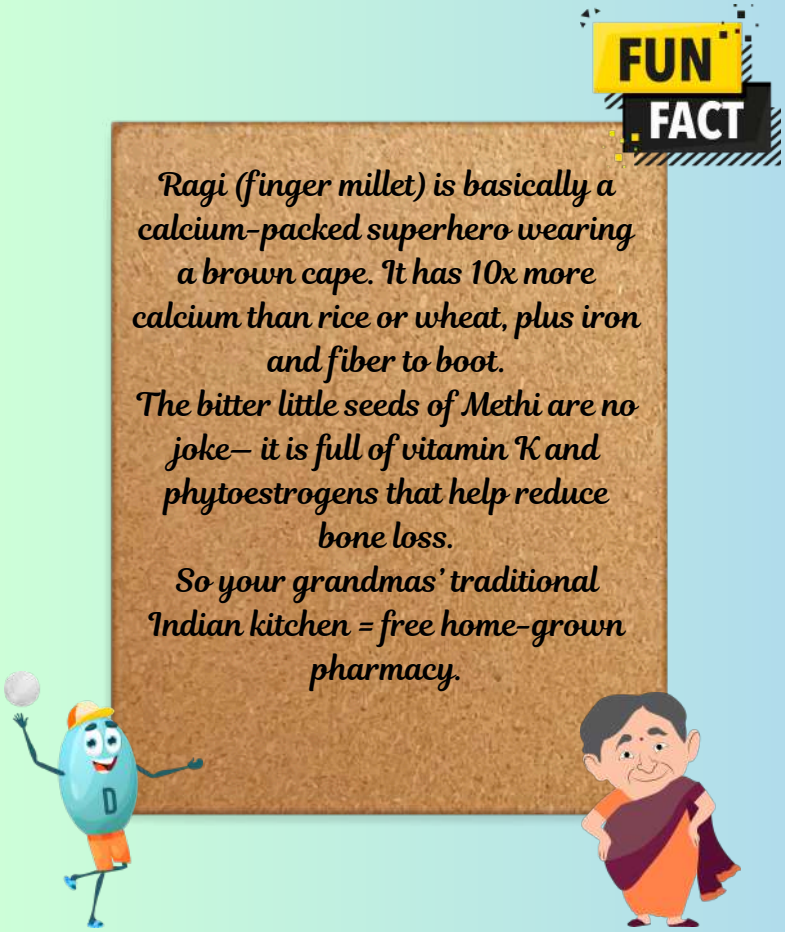
Beyond bone and fall outcomes, vitamin D has been investigated for its potential effects on cognition and muscle function. In the **SYNERGIC trial** conducted in Canada, older adults with mild cognitive impairment received combinations of physical exercise, cognitive training, and vitamin D (10,000 IU per week). The study found that the multi-domain intervention modestly improved global cognition, but vitamin D supplementation alone did not provide independent cognitive benefits. This suggests that while vitamin D may support overall health, it is unlikely to reverse or significantly delay cognitive decline on its own. (7)

From a biological perspective, vitamin D interacts with vitamin D receptors (VDR) in skeletal muscle, influencing muscle cell proliferation, differentiation, and mitochondrial function. Low vitamin D levels are associated with sarcopenia, characterized by progressive loss of muscle mass and strength. This condition contributes to frailty, falls, and functional decline in the elderly. A narrative review by Remelli et al. summarized evidence linking vitamin D deficiency with muscle fiber atrophy, especially of type II fibers, which are critical for strength and fast movement. (8) While some clinical trials suggest vitamin D supplementation improves muscle strength and physical performance, findings remain inconsistent due to heterogeneity in study populations, baseline vitamin D status, and assessment methods. Nonetheless, biological plausibility and observational data support maintaining sufficient vitamin D levels as part of sarcopenia prevention.

For clinicians, an important clinical question remains - whether routine testing of vitamin D levels should be done in all older adults, or if supplementation should be initiated empirically. Current evidence and guidelines suggest that **routine screening of 25(OH)D levels in all asymptomatic older adults is not necessary**.(9) The U.S. Preventive Services Task Force (USPSTF) and several expert groups advise against widespread vitamin D testing in community-dwelling individuals without risk factors. Instead, **vitamin D supplementation can be considered empirically, especially in older adults with limited sun exposure, mobility issues, or those at high risk of falls and fractures**. The VITAL trial specifically enrolled participants who were not selected for low vitamin D status, yet supplementation had no benefit on fractures, emphasizing that universal screening does not improve outcomes.

The 2024 meta-analysis by Tan et al. also found benefits only in individuals with low baseline vitamin D levels and not in those with normal levels, suggesting a targeted supplementation strategy without the need for routine blood tests may be more appropriate and cost-effective.(6)

Overall, the current body of evidence indicates that vitamin D supplementation in older adults should be personalized. Routine high-dose supplementation in the general population appears unnecessary and ineffective for fracture prevention. However, daily doses of 800–1000 IU may be beneficial in reducing falls, especially among those with documented deficiency or limited sun exposure. When combined with calcium, long-term benefits to bone density and possibly fracture prevention may be observed. Clinicians should assess baseline risk factors and tailor interventions accordingly, emphasizing a multifactorial approach to fall and fracture risk reduction in aging populations, without over-reliance on routine blood testing.



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Insights into comprehensive elder care: learning from recent trials

~ Dr. Venugopalan G
Associate Professor,
Department of Geriatrics
JIPMER, Puducherry

A lot of interesting articles were published in the past 3 months (February to April 2025). I have cherry-picked a few which have a larger scope of utilization in clinical practice and research of the readers. I hope the readers go through the articles mentioned here in detail and appraise them for your benefit.

An interesting article published in NEJM by the Global Cardiovascular Risk Consortium on the Global effect of Cardiovascular risk factors on lifetime estimates draws our attention to understanding the impact and scope of primary prevention of Cardiovascular Diseases (CVD) and mortality. The individual-level data from 133 cohorts across 6 continents were used for this study. The lifetime risk of 5 risk factors: arterial hypertension, hyperlipidemia, underweight and overweight or obesity, diabetes, and smoking at 50 years of age were studied to determine the CVD and all-cause mortality up to 90 years of age. It was found that these 5 factors contribute to 24% (95% CI 21-30) among women, and 38% (95% CI, 30-45) among men, of CVD. The additional life-years free of CVD and death were 13.3 years and 14.5 years for women, and 10.6 years and 11.8 years for men, when all these 5 risk factors are absent at 50 years of age. This finding is very relevant for people working to increase the life and health span of the population.

Another interesting study from China looked at the impact of Blood pressure (BP) reduction and all-cause dementia in people with uncontrolled hypertension. This is a cluster randomized controlled trial, done in rural communities in China, where 163 villages received non-physician community healthcare provider-led intervention, and 163 villages received usual care, with 33,995 individuals, ≥ 40 years of age with uncontrolled hypertension were studied. In this study, intensive BP targeting (SBP < 130 mm Hg and DBP < 80 mm Hg) was compared with usual care, in the risk of all-cause dementia over 48 months. The mean age of the population was 62.5 years with about 61% women, with high baseline BP and CVD risk scores. At the end of the intervention period, the SBP and DBP were lower by 20.1 and 8.4 mm Hg in the intervention group, with about 22% higher adherence. All-cause dementia, determined by the Mini-Mental State Examination (MMSE) and Functional Activity Questionnaire (FAQ), was lower by 15% in the intervention group (unadjusted RR: 0.85, 95% CI 0.76-0.95), (all-cause dementia 4.59% vs 5.40%) as compared to the control group. The effect was significant even after multiple adjustments and sub-group analysis, without any significant increase in the adverse events.

The open-label nature of the study was compensated by a blinded outcome assessor (Neurologist). The lack of a baseline dementia score is a limitation. They also did a meta-analysis with four previously published studies, and the risk of dementia was lower by 15% in the intensive BP control group (RR: 0.85, 95% CI 0.78-0.92). This is an important study for physicians treating older adults.

An analysis of two large datasets to find the optimal dietary pattern for Healthy Ageing was published in the Nature in March 2025. This analysis looked at 30 years of follow-up data from the Nurses Health Study and the Health Professionals follow-up study, where long-term adherence to eight dietary patterns and ultra-processed food consumption pattern was studied with the outcome measures of healthy ageing defined by living to 70 years of age free of chronic diseases; cognitive, physical, and mental health. About 9,771 (9.3%) participants achieved healthy ageing. Long-term adherence to the dietary patterns, and higher intake of fruits, vegetables, whole grains, unsaturated fats, nuts, legumes, and low-fat dairy products were linked to higher odds of healthy ageing. Higher intake of trans-fats, sodium, sugary beverages, and red or processed meats was inversely associated with healthy ageing. It was also found that higher consumption of ultra-processed food (UPF) is associated with lower odds of intact cognitive health, physical and mental health, living free of chronic diseases, and reaching the age of 70 years; with an overall 32% lower odds of healthy aging. The participants in the highest quintile of energy-adjusted dietary pattern score had more physical activity, higher socio-economic status scores, and slightly less body mass index (BMI) than those in the lowest quintile, suggesting potential confounders/effect-modifiers on the impact of nutrition with healthy ageing. The study also had other limitations as the cohort is composed of healthcare professionals, belonging to higher socio-economic strata and more access to medicine and food choices which will limit the generalizability of the results.

Another study with an interesting study design was published in the Lancet Healthy Longevity. This study used a Target Trial Emulation (TTE) design to study the effectiveness and safety of using statin in the primary prevention of CVD in older patients with chronic kidney disease who have hypercholesterolemia. Data from about 96 diverse trials were used to create unique individuals in the age group of 60-74 (n=19,423), 75-84 (older, n=22,565), and ≥ 85 years (very old, n=8,811), where the data were emulated for this study specific objective, which is the essence of TTE study design. The results showed a benefit of primary prevention with statin in older and very old adults in terms of reduction of overall CVD incidence, all-cause mortality, myocardial infarction, heart failure, and stroke. Conducting a RCT in this age group is challenging and TTE design helps overcome such challenges.

Moreover, the updated reporting guidelines for randomized trials were published in 2025. The Consolidated Standards of Reporting Trials (CONSORT) statement for reporting randomized trials was updated in 2025 with revision of various checklist items, Standard Protocol Items: Recommendations for Interventional Trials (SPIRIT) statement for publication of protocol of randomized trials was updated in 2025 along with CONSORT update. WHO has also updated the guidance on reporting summary results in clinical trial registries.

Clinical Vignette

~ Dr. Anupam Kumar

An 80-year-old woman presents to the clinic for routine follow-up. She has a history of hypertension and osteoarthritis but no prior fractures. She reports decreased physical activity due to joint pain and is concerned about her risk of “bone thinning” after her friend recently suffered a hip fracture.

Question:

1. Risk Identification:

What are the key risk factors and appropriate screening tools to assess this patient’s risk for osteoporosis and future fractures?

2. Treatment Optimization:

How should pharmacological and non-pharmacological treatments be selected and tailored for this patient, considering her age, comorbidities, and limited mobility?

3. Fracture Prevention and Rehabilitation:

What strategies should be implemented to reduce her risk of falls and fractures, and what would be the approach if she were to sustain a low-impact fracture in the future?

Image-based Question

Identify the conditions shown in figure 1 and figure 2

FIgure 1

FIgure 2

Answers for previous issue

~ Dr. Pankhuri Saxena

1. Diagnosis- Probable Diagnosis: Dementia with Lewy Bodies (DLB) [By revised Clinical criteria of DLB]

2. Management

A. Non-pharmacologic Management:

1.Education and Support:

- Educate caregivers on disease course
- Safety measures for fall prevention
- caregiver burden assessment.

2.Cognitive Rehabilitation:

- ·Occupational therapy, memory aids, and structured routines.

3.Environmental Modifications:

- Adequate lighting, minimizing shadows at night to reduce hallucinations.
- Remove fall hazards.

4.Sleep Hygiene and RBD Management:

- Safety measures during sleep (padding, removing sharp objects).
- Maintain regular sleep-wake cycle.

B. Pharmacologic Treatment:

1.**Cognitive Symptoms:**

- Cholinesterase inhibitors: Rivastigmine (preferred) or Donepezil
- Improve cognition and may reduce hallucinations.

2.Parkinsonism:

- Levodopa (lowest effective dose)

(Caution: may worsen hallucinations).

- Avoid dopamine agonists due to risk of psychosis.

3. Psychiatric Symptoms:

Visual hallucinations:

- Mild: Often don't need treatment if insight is preserved.
- Severe/distressing: Consider quetiapine or clozapine (with caution).
- Avoid typical antipsychotics and risperidone – can cause severe neuroleptic sensitivity and worsen motor symptoms.

4.REM Sleep Behavior Disorder:

- Clonazepam or melatonin

5.Autonomic Dysfunction:

Orthostatic hypotension:

- Non-pharmacologic: Increased salt/fluid intake, compression stockings.
- Pharmacologic: Fludrocortisone, Midodrine (if symptomatic)

C. Monitoring and Prognosis:

- Regular follow-up for cognitive, motor, and autonomic symptom progression.
- Median survival: 5–8 years after symptom onset.
- Monitor for complications: aspiration, falls, infections, caregiver burnout.

The correct answer was given by
Dr. P. Aravind Babu
Assistant Professor
Department of Geriatrics
Govt Medical College, Virudhunagar, Tamil Nadu

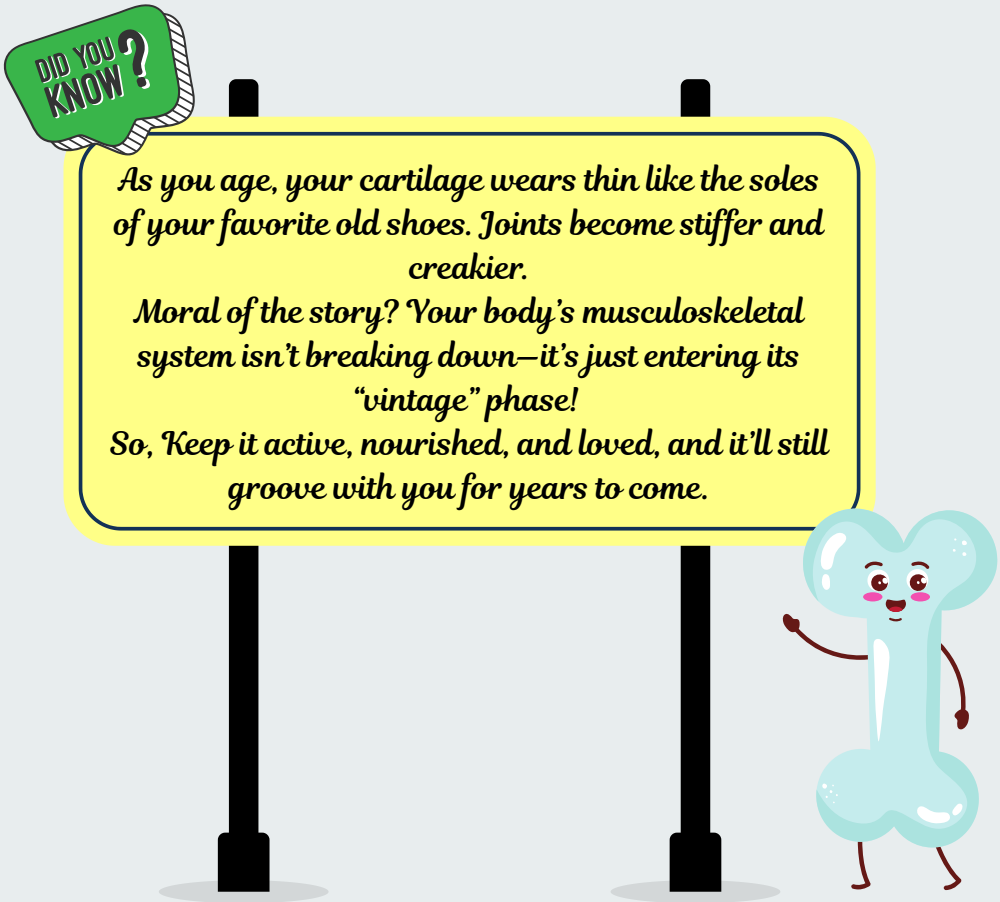
Answers for image based question

~ Dr. Surjitkumar Singh

Image 1 (answers)
Hole with Dot sign (hyper intense peripheral rim enhancing lesion)
Cyst with scolex in a patient of Neurocysticercosis.

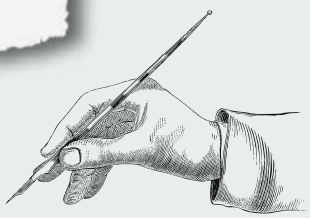
Treatment
1. Antiepileptic
2. corticosteroid - dexamethasone, prednisolone
3. anti parasitic - albendazole , praziquantel

Image 2 (answer)
Bird beak sign/Hummingbird sign seen in Progressive Supranuclear Palsy
It is a form of synucleinopathy due to lewy body deposition.



Blue, blue: The code without hue

Dr. Yatharth Malik



Code blue code blue
And the family lose their hues
Hands tremble, voices mumble
Dread is worse than death the patient say
But .....
There is a pair of hands from no where
And hustle bustle everywhere
Machines beep, meds given
Not a sigh taken
By those hands.....
Yet, admist this, there is brain behind
Trying his best to think with his mind
Every compression to every breath
There is a peace in chaos and death
That white coater, tries his best.....
Yet he may fail
But even death doesn't kill his tale
Alas! He can't sway
As another patient on the way
The family has been counselled, he reports always

After 10 years I understand.....
The name code blue
For the stethoscope holder comes out of the blue

HAPPY DOCTOR'S DAY

Photo Gallery

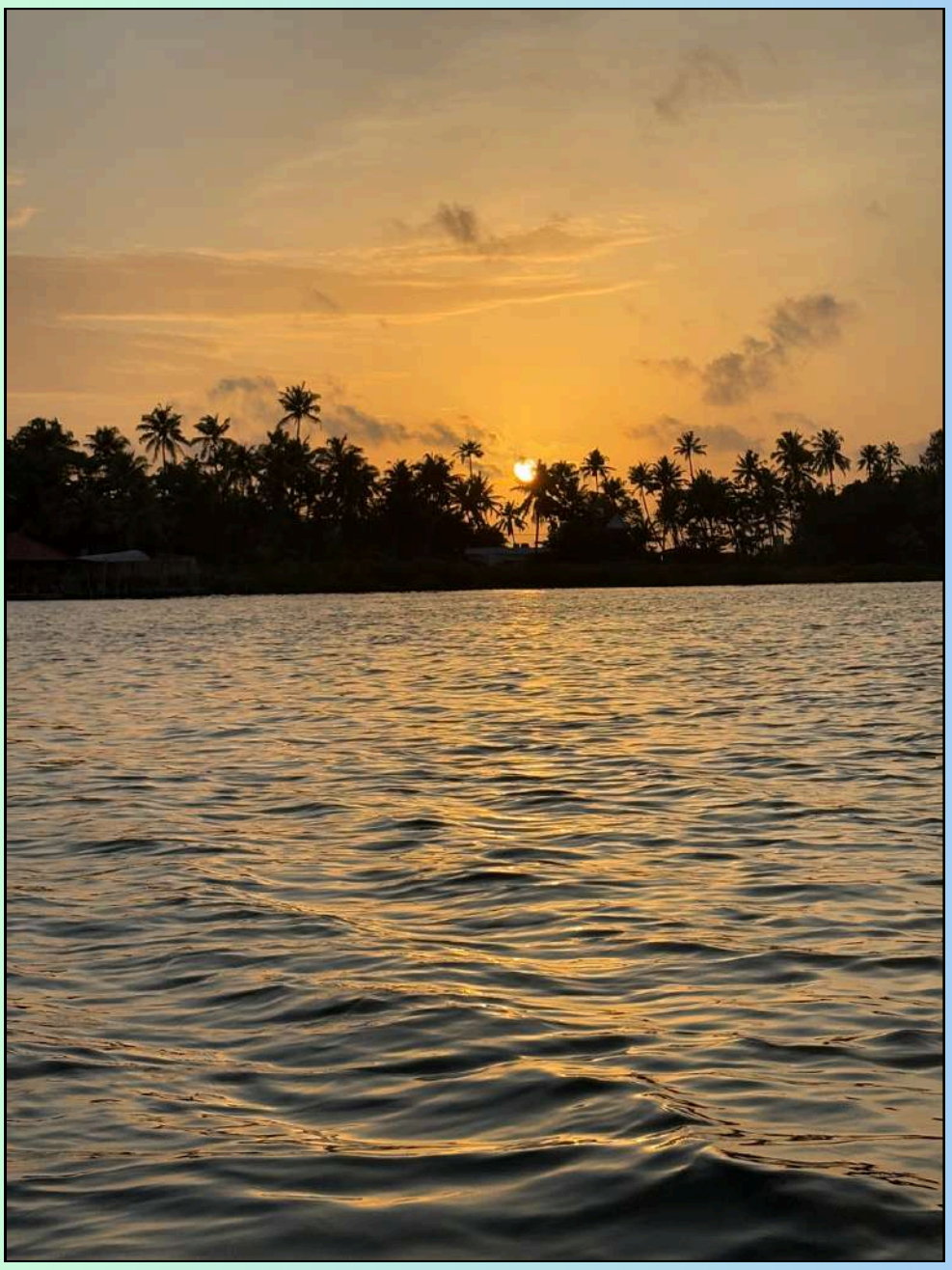
Inter-departmental Quiz Competition held on occasion of World Parkinsons Day on 11 April

Residents taking active participation in teaching resistance training exercises for Fall prevention to older patients

Poster competition among Nursing students on World Parkinsons Day on 11 April.

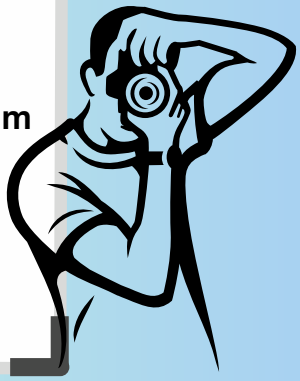
Public awareness program by the Department on Parkinson's and related disorders

Flashlight



~ Contributed by
Dr. VS Sai Sachin

Got a knack for photography ?
Then hurry up and send in your submissions to us at
silverliningsaiimsrishikesh@gmail.com
We will feature it in our next issue.

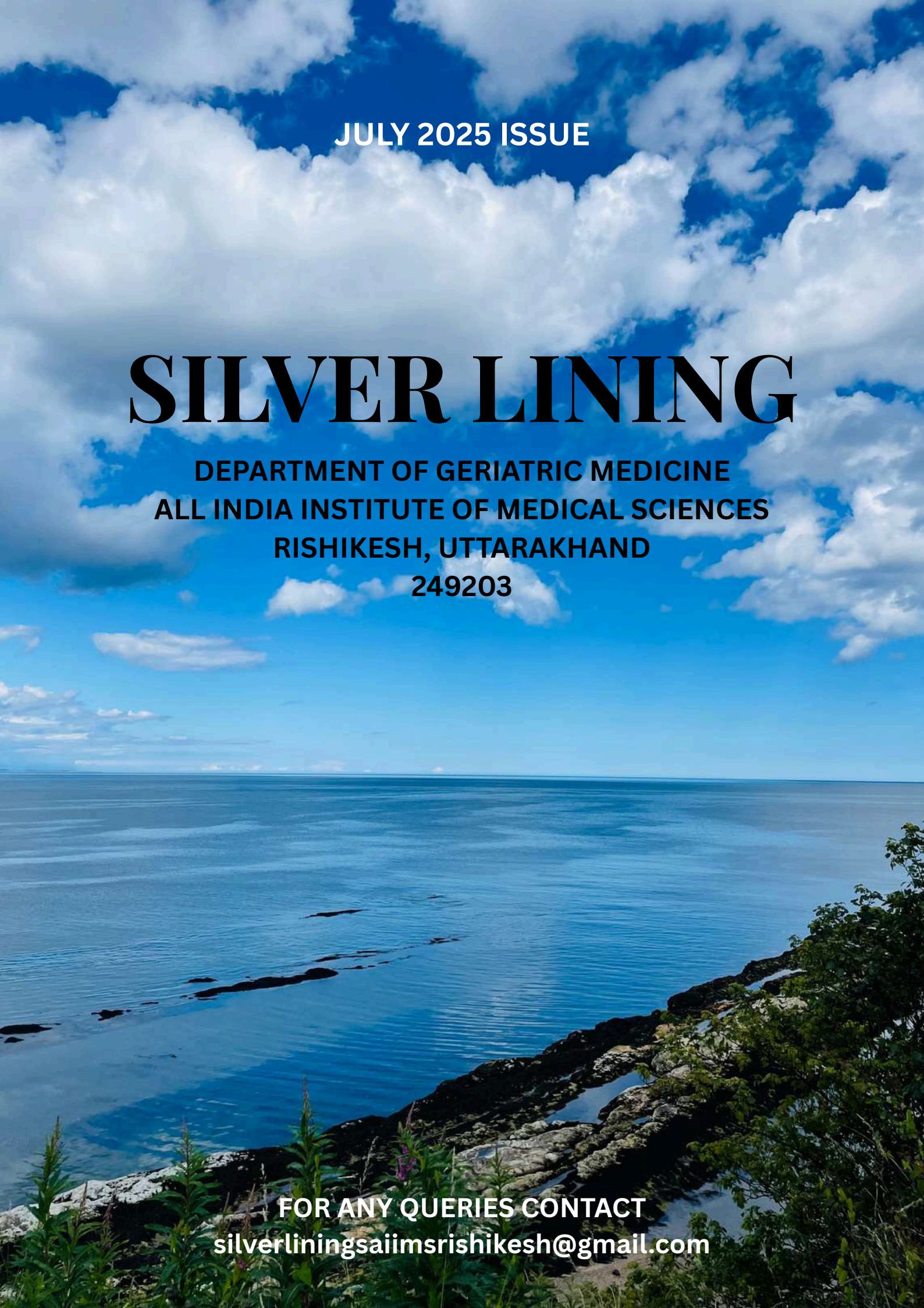


SEND IN YOUR SUBMISSIONS

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**



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