



October 1, 2024
Volume 1, Issue 2

SILVER LINING

GERIATRIC MEDICINE NEWS LETTER

Diabetes in older adults

Functionality in older adults

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FROM EDITORIAL DESK



~Dr. Monika Pathania

“Scare “ to “Care” medicine in elderly diabetics :Simple Non pharmacological interventions for busy outpatient settings.

As clinicians announcing a diagnosis of chronic disease like diabetes may be a routine for the doctor in a busy Outpatient but for the person who is the audience of this announcement of this disease is similar to a bad news. For elderly, it's the announcement, that takes away the nectar of living, mithais and delicious foods. Our society has a stigma attached to the treatment of diabetes and the fear of a lifelong ordeal. For clinicians its advisable to make the announcement skillfully, diligently so that they practice “care medicine” and not “scare medicine”. This may lead to increase in blood sugar as fear leads to cortisol secretion that leads to hyperglycemia indirectly. Old age is the time where in the habits are difficult to change, 2 minute sermon from the clinician like stop all sugars, start walking, stop smoking, take medicine on time etc has to be replaced by gradual handholding, encouragement and suggesting culturally appropriate and affordable solutions.

Few simple suggestions that can be reinforced for Indian geriatric diabetics in busy outpatient setting irrespective of the department they present to, are:

•Diet :

Some of the suggestions given below are just Basic dietary advise that is to be discussed with all elderly diabetics, who are presenting to any OPD. Its for general discussion with the elderly

diabetic patient presenting to OPD s (other than geriatric clinics), where detailed diet plan is not feasible due to time constraints. It is advisable to ask the elderly diabetic about their daily routine of waking up from bed and time the meal is served to them . Encouraging them to add soaked 3-4 almonds/apricot/resins/walnut as per their taste will add anti oxidants to their routine. Advise them to add millets/whole grain in atleast one of their meals as per availability in their area e.g. Jowar(sorghum), mandua/koda, barley, jau. These are not only low in glycemic index but also have added advantage of having essential vitamins, minerals and fibre. Better to make each one separately rather than mixing them or using multigrain preparation. Add regionally available legumes, salads. Cold pressed/kachi Ghani less processed culturally acceptable oils to be used. Ghee is not prohibited , A2 Ghee in very little amount can be used over chapatti. Red rice/Black rice can be used over basmati /white polished rice and its better to use either half small bowl of rice or one medium size roti rather than both together. Basically the plate should have more colourful food items with more vegetables/pulses/curd than chapaties/rice. Seasonal Fruit or fruit as per their preference should be taken between the meals rather than along with the meal. Clinicians should avoid making them guilty of not eating kiwi or avocado or other fruits which are in trend but either they are not preferred by elders or they are not economical. It is a



CONTENTS

MANAGEMENT OF DIABETES IN OLDER ADULTS

FUNCTIONALITY IN OLDER ADULT

CASE SCENARIO

FUN FACTS

QUESTIONS

ANSWERS OF PREVIOUS QUESTIONS

common practice to take biscuit which unfortunately is prescribed by many dieticians at snack time, instead elderly should be advised to return to traditionally used but currently forgotten snacks like roasted chana/black grams, sprouts, roasted makhana /fox nuts, flaxseeds, depending on the region to where the elderly belongs. Addition of traditional chutneys to the meal will make meals more interesting for the elderly who struggle from age related taste issues. Better to take lighter meal at dinner time and eat on early in the evening roughly before 8pm, something that has been practiced in our country since ages. It is advisable to send the patients experts equipped with subject knowledge and experience in making specialised detailed diet plans.

·There is good evidence of studies supporting use of methi/fenugreek soaked overnight/powdered, bittergourd, Use of amla(Indian gooseberry), cinnamon and Nigella/kalonji. Keeping our mind open to the best of whatever any system of medicine can provide for the benefit of patients can work wonders for the patients the way quinine, artemisinin etc did in fatal malaria. Prejudice is detrimental when solution is the priority.

·Physical activity: Advising elderly to walk 30 minutes every day preferably with their friends cannot only make them active but add some endorphins to fight their diabetes and stress. Those who are compliant can be taught some simple strength training excercises, encouraged to do simple household chores on their own as per their capability.

·Yoga : yoga encompasses asana pranayama and meditation. There is a lot of evidence on yogasanas and glycemc control. Yogasanas are to be learnt from trained experts not only for correct postures but also for forming a routine. There are published studies on yogasanas like bhujangasana, vrikhasana, matsyendrasana etc being effective in glycemc control. Elderly need to do exercise /yoga under supervision initially and then when they are confident, they can slowly do on their own with frequent followups with experts. There is ample evidence showing Meditation reduces factors /hormones that lead to rise in blood glucose levels. Practicing guided meditation/ yog nidra is effective. Good Quality sleep is the byproduct of meditation that indirectly improves hyperglycemia.

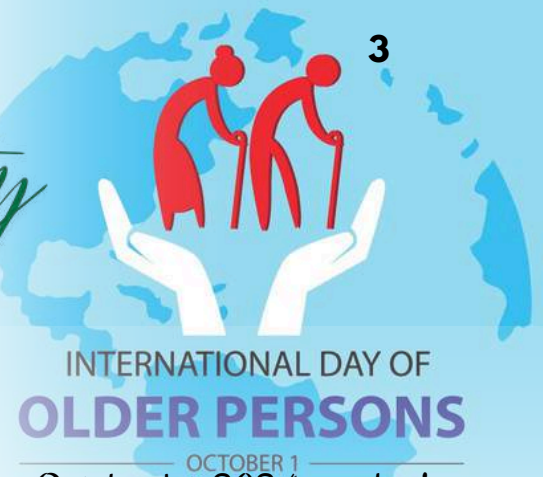
·Sleeping on time, no screens after ten at night and proper sleep hygiene to be advised.
·Strongly advising on quitting smoking ,alcohol and weight management is to be reinforced at each visit.
·Counselling the family to sit with elders at least 10-15 minutes per day minimum and just listening to them so that they feel cared for, will go a long way in them dealing with diabetes.

Clinicians must understand that diabetes management needs change in behaviour and that's a slow process. Not only the family but clinician must have some patience dealing with elderly diabetics. Rather than making the elders feel guilty or blaming them for their sugars not getting controlled, it's better to reassure them and take them in confidence that the clinician will guide them through their ordeal. Since most of elderly diabetics are dependent on their family members, the clinician must advise keeping in mind the feasibility with the caregiver as well. Prescribing solely based on western guidelines in Indian scenario without considering each patient individually, will result in "good looking" prescriptions that may be "good for nothing" in the battlefield against diabetes!

*Enjoy reading this
issue*



Ageing with dignity



This year, The International Day of Older Persons, celebrated on October 1st, 2024, emphasizes the theme of "Ageing with Dignity: the importance of Strengthening Care and Support Systems for Older Persons Worldwide." As the global population ages, it is essential to develop robust care frameworks that address the unique needs of older adults. Dignified aging involves ensuring that older individuals are treated with respect, have access to necessary healthcare, and retain their independence as long as possible. Unfortunately, many older adults face barriers such as limited access to healthcare, social isolation, and a lack of supportive services, which can significantly impact their quality of life. Aging brings unique challenges, including managing chronic illnesses, mobility issues, cognitive decline, and increased vulnerability to acute health events. Beyond medical care, older adults also require emotional and social support, as isolation and loneliness are common concerns.

Strengthening care systems for older adults involves several critical components. This includes providing accessible and affordable geriatric-specific healthcare delivery, integrated community and social support systems, family education and awareness. Additionally, long-term care facilities, such as nursing homes, must prioritize the dignity and autonomy of residents, ensuring high standards of care.

Global cooperation and policy advocacy are essential to prioritize the needs of aging populations. Investments in healthcare infrastructure, age-friendly environments, and support systems can improve the lives of older adults worldwide. For healthcare professionals, the 2024 theme serves as a reminder that holistic, compassionate care is key to ensuring older adults age with dignity, promoting their overall well-being and maintaining their quality of life.

~Dr. Sudeep Mathew George

MANAGEMENT OF DIABETES IN OLDER ADULTS

~Dr. Parul Bhutani

~Dr. Pankhuri Saxena

Introduction

Diabetes is a highly prevalent health condition in the ageing population. As the population demographics are changing and shifting towards older population, the number of older adults living with diabetes is expected to increase rapidly in the coming decades. Over half of people above 65 years (older adults) have prediabetes and one quarter of them have diabetes. Among all forms of diabetes, Type 2 diabetes mellitus is the most common type found in the older (1)

How Diabetes related to Ageing

Ageing is associated with the development of diabetes. It has been noted that in normal ageing, there is a 2 mg/dL/decade rise in fasting plasma glucose, placing elderly patients at increased risk for the development of diabetes. Beta cell function is strained not only by age-related decline but also by increasing insulin resistance. Weight gain and decreased muscle mass are often seen with increasing age, resulting in worsened insulin resistance at the level of muscle and fat. Additionally, in the elderly there are often concomitant diseases, decreased activity, and medications which can worsen insulin resistance. (3) Hence, as a result of interactions among genetics, lifestyle, and aging, older adults are at high risk of developing prediabetes and diabetes. (Figure1) (1)

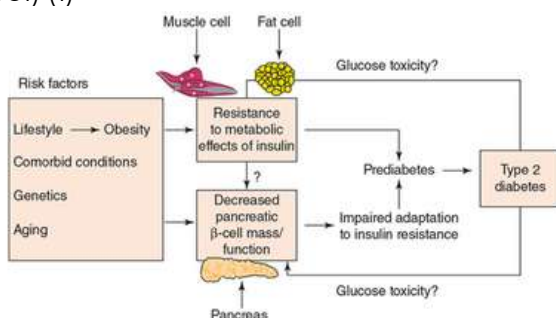


Figure 1- Model for age-related hypoglycemia. Biological changes associated with risk factors give rise to alterations in both insulin secretion and insulin sensitivity. Ref- Hazzard's Geriatric Medicine and Gerontology, 8e. McGraw-Hill Education; 2022



Screening of Diabetes Mellitus

The ADA recommends that all adults over age 45 are screened for diabetes and prediabetes, and if the results are normal, it can be repeated in three years. If the patient is found to have prediabetes (impaired fasting glucose with FPG 100-125 mg/dl, impaired glucose tolerance with 2-hour glucose 140-199 mg/dl on 75-gram oral glucose tolerance test, or A1C 5.7-6.4%), screening is recommended yearly. (2)

Diagnosis Of T2DM in older adults

Diabetes in older adults is also a highly heterogeneous condition. While some older individuals may experience sufficient hyperglycaemia to develop mild classical symptoms like polydipsia, polyphagia, and polyuria, others may present with unexplained gradual weight loss. In many cases, older adults may show atypical signs of hyperglycaemia, such as falls, urinary incontinence, fatigue, or confusion, which can mimic geriatric syndromes. Since type 2 diabetes can remain undiagnosed for years, some older adults may first present with complications such as vision loss, with retinopathy noted on examination, proteinuria, or symptomatic peripheral neuropathy. Older adults with diabetes are at increased risk for both macrovascular and microvascular complications, significantly affecting their quality of life. Conditions like end-stage renal disease (ESRD), vision loss, myocardial infarction, stroke, peripheral vascular disease (PVD), and peripheral neuropathy all become more prevalent with advancing age. (1) Despite these differences, the diagnostic criteria for diabetes—including fasting blood glucose (FBG), postprandial blood glucose (PPBG), and HbA1c levels—remain the same for older adults as for younger populations, as same glucose thresholds are associated with complications across all age groups. (1,2)

Diabetes and Geriatric Syndrome

Older adults with diabetes have higher rates of premature death, functional disability, accelerated muscle loss, and coexisting illnesses, such as hypertension, coronary heart disease, and stroke, than those without diabetes. At the same time, older adults with diabetes are also at greater risk than other older adults for several common geriatric syndromes, such as polypharmacy, cognitive impairment, depression, urinary incontinence, injurious falls, persistent pain, and frailty. (Figure 2) These conditions may impact older adults' diabetes self-management abilities and quality of life if unaddressed. (2)



Figure 2- Diabetes and related geriatric

Hypoglycemia in Diabetic Older adults

Older adults with diabetes are increase risk of developing hypoglycemia due to various risk factors (Table1). Most frequently encounter risk factors are therapeutics-insulin and drug induced. Therefore, ADA has recommended that older adults with diabetes should be assessed for risk factors of hypoglycemia and episodes of hypoglycemia should be ascertained and addressed at every routine visits.

For older adults with type 1 diabetes and with type 2 diabetes on multiple daily doses of insulin, continuous glucose monitoring should be considered to improve glycemic outcomes and decrease glucose variability. Cognitive decline has been associated with increased risk of hypoglycemia, conversely, severe hypoglycemia has been linked to increased risk of dementia (figure3).

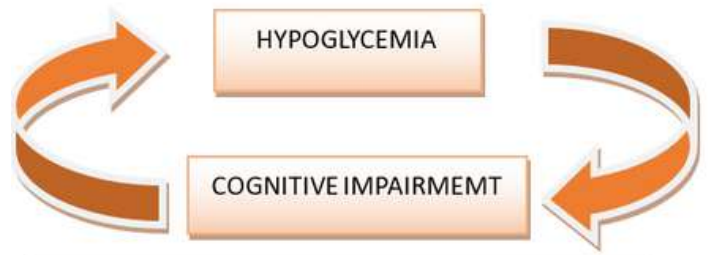


Figure 3- relationship between hypoglycemia and cognitive impairment in older adults

Treatment Goals in Older Adults

The management of older adults with diabetes is complicated by their diverse clinical, cognitive, and functional characteristics. Health care providers must account for this variability when establishing and prioritizing treatment goals. Older adults with a sufficient life expectancy to benefit from intensive diabetes management, who have preserved cognitive and physical function, and engage in shared decision-making can be treated with similar therapeutic approaches and goals as younger individuals with diabetes. In contrast, for those with advanced diabetes-related complications, life-limiting comorbid conditions, or significant cognitive or functional impairments, setting less stringent glycemic targets is appropriate. In individuals receiving palliative or end-of-life care, the focus should shift to preventing hypoglycemia and symptomatic hyperglycemia while minimizing the burden of glucose management. As organ function declines, it may be necessary to deintensify or discontinue certain treatments.

Table 1 -RISK FACTORS FOR HYPOGLYCEMIA	
Therapeutic	<ul style="list-style-type: none"> • Insulin, Sulfonylurea
Physiologic	<ul style="list-style-type: none"> • Impaired autonomic function • Diminished glucagon secretion • Kidney or hepatic failure • Cognitive impairment • Sensory impairment (vision hearing) • Functional impairment
Behavioural	<ul style="list-style-type: none"> • Poor nutrition • Use of alcohol or other sedative agents
Others	<ul style="list-style-type: none"> • Polypharmacy

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

Table 2—Framework for considering treatment goals for glycemia, blood pressure, and dyslipidaemia in older adults with diabetes (Ref- American Diabetes Association, 13. Older Adults: *Standards of Care in Diabetes—2023*. *Diabetes Care* 1 January 2023)

Treatment Options in Diabetic Older Adults

Lifestyle Modification-

ADA recommended dietary control with optimal nutrition and protein intake for older adults; regular exercise, including aerobic activity, weight-bearing exercise, and/or resistance training, should be encouraged in all older adults who can safely engage in such activities. For older adults with type 2 diabetes, overweight/obesity, and capacity to safely exercise, an intensive lifestyle intervention focused on dietary changes, physical activity, and modest weight loss (e.g., 5–7%) should be considered for its benefits on quality of life, mobility and physical functioning, and cardiometabolic risk factor control. (2)

Pharmacological Control-

As older adults with type 2 diabetes at increased risk of hypoglycemia, medication classes with low risk of hypoglycemia are preferred. Overtreatment of diabetes is common in older adults and should be avoided. Deintensification of treatment goals and simplification of complex insulin therapy (figure 3) is recommended to reduce the risk of hypoglycemia and polypharmacy if it can be achieved within the individualized A1C target. (2)



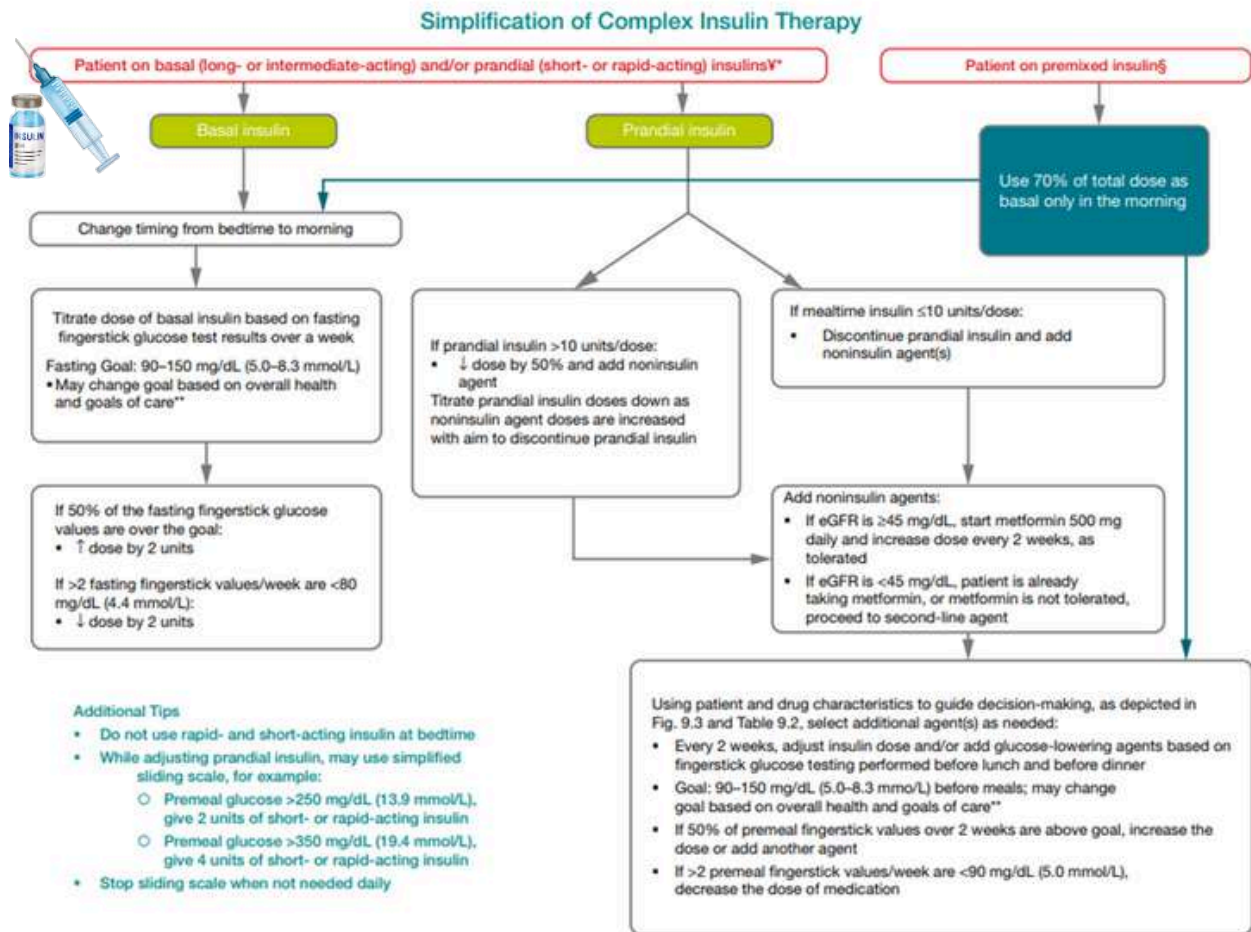


Figure 4—Algorithm to simplify insulin regimen for older adults with type 2 diabetes. eGFR, estimated glomerular filtration rate. *Basal insulins: glargine U-100 and U-300, detemir, degludec, and human NPH. **See Table 13.1. ‡Prandial insulins: short-acting (regular human insulin) or rapid-acting (lispro, aspart, and glulisine). §Premixed insulins: 70/30, 75/25, and 50/50 products. (Ref- American Diabetes Association, 13. Older Adults: Standards of Care in Diabetes—2023. *Diabetes Care* 1 January 2023)

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FUN FACT

As we age, our lungs don't exactly retire, but they do get a bit lazy! The respiratory muscles weaken, lung tissue becomes less elastic, and airways may stiffen up, making it a little harder to breathe deeply. It's like your lungs are slowly shifting to "cruise control."

But here's the exciting part: unlike obstructive lung diseases like asthma or COPD, which block airflow, or restrictive diseases like fibrosis that make the lungs stiff, aging lungs don't necessarily trap you. It's more of a gentle slowdown rather than a full-on roadblock. So, while you may not be sprinting up stairs as fast as you did at 20, your aging lungs can still get you there, just at a more relaxed pace!

FUNCTIONAL ABILITY IN OLDER ADULTS: A ROADMAP TO HEALTHY AGING

~Dr. Parul Bhutani

~Dr. Kritartha Kashyap

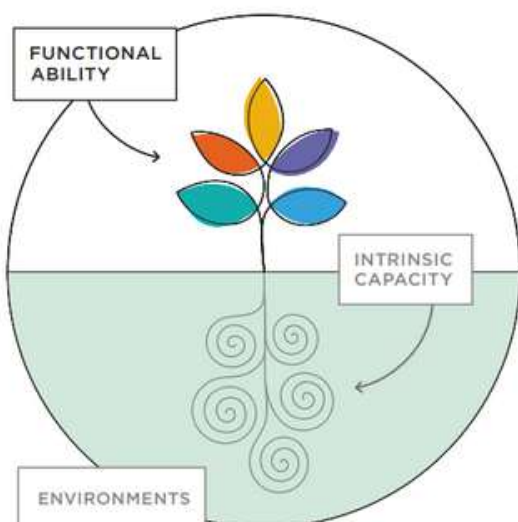
~Dr. Neethu Sunny

INTRODUCTION

Most of the people, including healthcare professionals, commonly believe that the disease and functional decline that come with aging are inevitable and solely due to the "aging process." However, much of the physical decline and decreased physiological reserve often attributed to aging is actually the result of a complex interaction between disuse, environmental and lifestyle factors, disease, and genetics.

HEALTHY AGEING AND FUNCTIONAL ABILITY

As the global population ages, the focus of healthcare in older adults increasingly shifts toward maintaining and improving functionality. What is meant by functionality? In the geriatric population, functionality refers to the ability to perform everyday tasks and engage in physical and cognitive activities that ensure a reasonable quality of life. WHO has given us goal of Healthy Ageing in 2015 World report on ageing and health, that is helping people to develop and maintain the functional ability that enables well-being. Functional ability is defined as the "health-related attributes that enable people to be and to do what they have reason to value".



IMPLICATIONS OF FUNCTIONAL INDEPENDENCE

In clinical practice, assessing Activities of Daily Living (ADLs) in older adults provides valuable insight into their overall well-being. People above 75 have either a gradual or accelerated decline in ADL's.

The ability to perform ADLs tends to decline with age due to factors such as frailty, chronic illness, cognitive decline, and environmental challenges. According to studies, individuals over the age of 75 show a marked decline in their ability to perform both basic and instrumental ADLs. **But this decline in ADLs is not a marker of aging but a predictor of broader health outcomes.** Functional impairment in ADLs can serve as an early warning sign for underlying health conditions. For instance, an older adult struggling with dressing or bathing might be experiencing early stages of arthritis or neurological conditions such as Parkinson's disease.

Functional decline is associated with increased healthcare needs. Individuals with ADL impairments are more likely to require frequent medical visits, home care services, and hospital admissions, placing a significant burden on healthcare systems.

The decline in ADLs has also been strongly associated with higher mortality rates. Older adults who are unable to perform basic ADLs are at higher risk of adverse health outcomes, including death.

Functional impairment is often an indicator of underlying frailty, a condition that increases vulnerability to external stressors like infections or acute medical events. One of the primary reasons for nursing home admission is the inability to perform ADLs independently. Loss of ADL functionality often prompts families to seek long-term care services, highlighting the importance of early interventions to preserve these abilities and delay institutionalization.

GOAL OF GERIATRICIAN

As geriatrician, our role lies on not only in treating older adults or managing their comorbidities, but also to maintain or improve their functionality. Whatever type of functionality matter most to the individual, whether he wants to pursue a new hobby like gardening, or wants to continue his routine of exercise, or just wants to go to washroom on his own, is our goal of treatment that we give to them. Therefore, functionality varies from individual to individual even of same age and hence, our goal of treatment also varies from patient to patient, even of same age, even of same diseases. Functionality is not solely depended on treatment we give, it depends on intrinsic capacity of that individuals, the environment of the individual and interaction between them. Preserving functionality is crucial in promoting independence and reducing the burden of chronic illness and disability.

ACTIVITIES OF DAILY LIVING

Functional decline is a common issue faced by the elderly, making the understanding and assessment of functionality critical in geriatric care. We can assess functionality of older adults objectively at every visit by asking certain activities of daily living to track our goal of functionality. These Activities of Daily Living (ADLs) are the tasks that are essential for self-care and independent living. ADLs are broadly categorized into two types: basic ADLs (BADLs) and instrumental ADLs (IADLs)

Basic ADLs include fundamental self-care tasks such as bathing, dressing, eating, toileting, continence and transferring (e.g., moving from a bed to a chair). These tasks are essential for maintaining physical independence.

Instrumental ADLs, on the other hand, require higher cognitive functioning and include activities such as managing finances, handling medications, preparing meals, shopping, housekeeping and using transportation. These tasks enable an individual to live independently in the community.



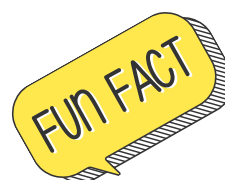
Maintaining functional independence is vital for preserving the autonomy and dignity of older adults. It is directly linked to better quality of life in them. Older adults who can perform ADLs independently are more likely to engage in social and recreational activities, which can enhance mental and emotional well-being.

EARLY INTERVENTIONS FOR FUNCTIONAL INDEPENDENCE

Given the significance of functionality, maintaining or improving ADL performance in older adults is a priority in geriatric care. Comprehensive Geriatric Assessment (CGA) is a multidisciplinary approach that evaluates the physical, cognitive, social, and psychological aspects of an older adult and can identify risk factors for functional decline and guide individualized care plans.

Several strategies can be employed to help older individuals retain their functional independence. Regular physical activity, including strength and balance exercises, can help improve mobility, prevent falls, and enhance overall physical function. For older adults experiencing cognitive decline, engaging in cognitive exercises and activities can help slow the progression of impairments in instrumental ADLs. The use of mobility aids, adaptive tools for dressing, and other assistive devices can help older adults perform ADLs more easily and maintain their independence for longer.

In conclusion, functionality as measured by the ability to perform ADLs, is a critical component of geriatric health. Declining ADL performance has significant implications for an older adult's quality of life, healthcare needs, and overall outcomes. Recognizing trends in ADL decline and addressing the underlying causes through timely interventions can significantly improve the health trajectory of older adults, allowing them to live more independently and with greater dignity. By focusing on preserving functionality, healthcare providers can play a pivotal role in enhancing the well-being of the aging population.



Did you know that intermittent fasting and calorie restriction could be your body's secret "fountain of youth"? By giving your cells a break from constant eating, they kick into autophagy mode—a fancy term for their self-cleaning routine where they clear out old junk and make room for shiny new parts! It's like giving your body a detox, helping to slow down aging from the inside out!

How to start? Begin with a simple 16:8 method—fast for 16 hours and eat within an 8-hour window. For example, skip breakfast and have lunch at noon, then wrap up dinner by 8 PM. Start small, listen to your body, and watch the benefits build up!

CLINICAL CASE VIGNETTE

~Dr. Vasu

74 years old male, known case of hypertension, controlled on medication, presented for evaluation of a 2-year history of neurologic symptoms. Her initial symptoms were slowness over right side more than left side, difficulty walking, and imbalance causing falls in all directions. One year after onset, she began to rub the fingers of her right hand on her leg. She lost dexterity in that hand, developed dystonic posturing, and switched to using her left hand. She then developed jerks of her right arm that were present at rest and increased when she tried to use her arm. When she lifted the right arm while sitting, her right leg would rise off the ground. She noticed that she had difficulty performing tasks with her left hand, although that hand was not particularly slow or stiff. The hand would sometimes move out of her control. Her voice became soft and hoarse, and she had difficulty finding the words she wanted and spoke in short phrases. She developed mild to moderate forgetfulness. She had been diagnosed with parkinsonism and given carbidopa/levodopa without benefit.

On examination she had no frontal release signs. Extraocular movements were intact without nystagmus or square-wave jerks. She had mild hypomimia and hypophonia. She had no resting tremor but had a coarse, jerky action greater than postural tremor of the left upper extremity. She had mild slowing and rigidity of the left upper extremity. Her right upper extremity could not be tested because of severe dystonic posturing that increased when she tried to use the hand. She had slowing of the right more than the left lower extremity. She could not imitate picking up a key with her left hand and could not identify a penny or paper clip placed in either hand. She could not recognize letters written on her left hand with her eyes closed. She needed assistance to rise from a chair. Her dystonic posturing of the right upper extremity worsened with walking, she had a slow gait with decreased stride, and she had very poor postural reflexes.

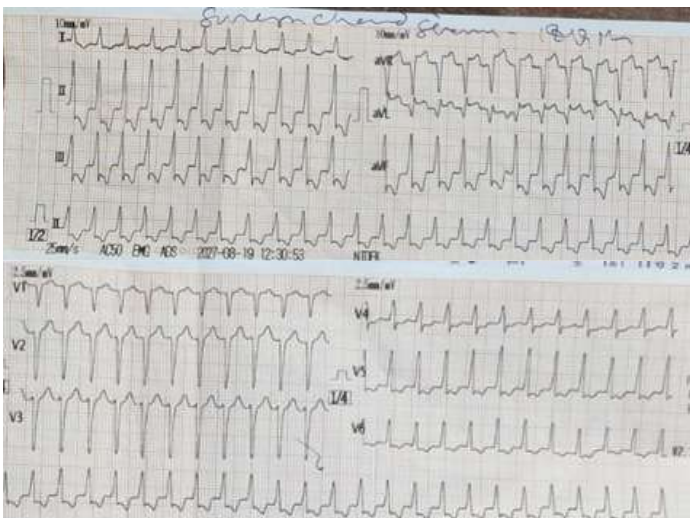
1. What is the most probable diagnosis?
2. What are clinical hallmarks of above condition?

IMAGE CHALLENGE

~Dr. Amit Pal Singh

Question 1

- What is the diagnosis?
- What is the drug of choice for this condition?



Question 2

- What is this sign?
- What disease is this sign seen in?
- What are the other immunological manifestations of the disease?

ANSWERS FOR LAST ISSUE

Clinical case vignette

Answers were compiled by Dr. Anupam Gangwar

1. There are multiple validated scales for frailty assessment. One of the most widely used scales is the Clinical frailty score. According to the clinical frailty scale our patient is living with very mild frailty group with a score of 4.

2. Blood pressure management in elderly patients was done based on the frailty status. AHA 2019 adapted the treatment strategy in 3 different functionality groups. Older adults with preserved functionality, loss of function/preserved ADL, and loss of function and altered ADL. However, in older adults with preserved functional status, we should consider full therapy to achieve outcomes similar to that of younger patients, i.e., 130 mmHg systolic and 80 mmHg diastolic. older adults who are otherwise healthy with few comorbidities and intact cognition and functional status should have glycaemic goals (HbA1c < 7-7.5%). In contrast, those with cognitive impairment, multiple coexisting comorbidities, or functional impairment should have less stringent glycaemic goals (HbA1c less than 8) as per ADA 2021 guidelines.

3. In October 2017, the WHO developed integrated care for older people (ICOPE) for screening conditions causing a decline in intrinsic capacity at the community level. The primary intended audience for these guidelines is health and social care workers in the community and at primary healthcare levels. the guidance supports healthy aging by addressing the following conditions associated with a decline in healthy aging i.e. cognitive decline, limited mobility, malnutrition, visual impairment, hearing loss, depressive symptoms, social care and support, and caregiver support. The first patient is screened with a questionnaire, after which further in-depth assessment is performed. Patient-centric management is done if the patient is found to have an impairment. A comprehensive geriatric assessment is an in-depth assessment of patients with suspected geriatric giants. If there is impairment patient is further evaluated by a multidisciplinary team keeping in mind the autonomy of the patient, a rehabilitation plan is formulated. The patient is reevaluated at timely intervals and progress is followed.

4. The following advice should be given to the patient-

- Management of his comorbidities as described in answer no.2.
- Strength and resistance training,
- aerobic/cardiovascular training
- improving nutritional status
- vision and hearing assessment

IMAGE CHALLENGE

1. A. Plain skull radiograph lateral view showing multiple bony lytic lesions.

B. With a history of chronic low back ache and fatigue, the patient is likely to have multiple myeloma causing multiple bony lytic lesions as the cause of low backache and anemia as the cause of fatigue.

2. The figure HRCT thorax, axial cuts showing multiple cavitary lesions.

The following are its differentials-

- Pulmonary tuberculosis
- Lung malignancy
- Wegner's granulomatosis
- Fungal pneumonia

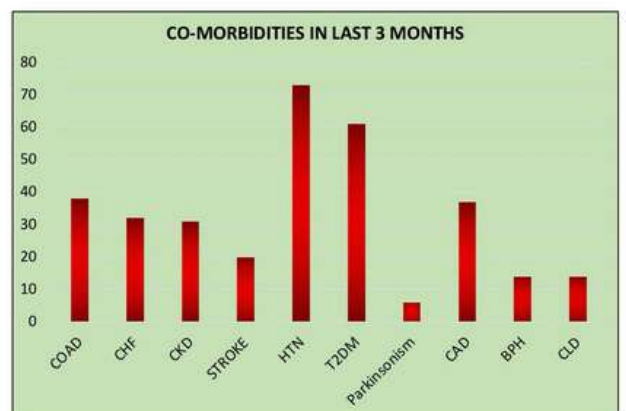
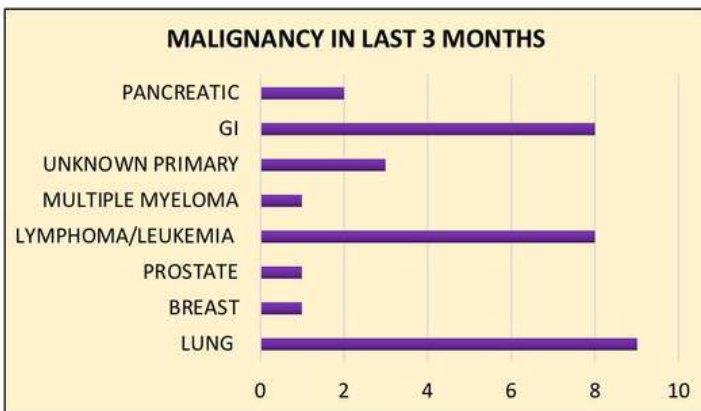
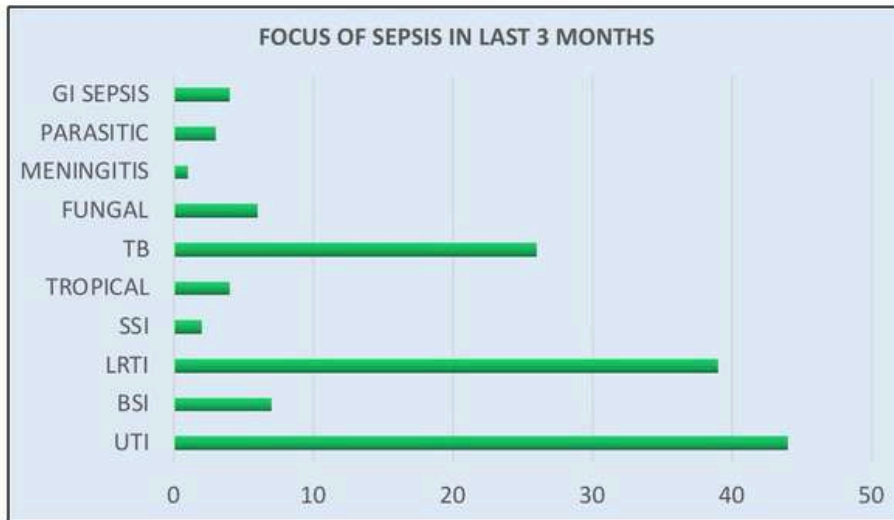
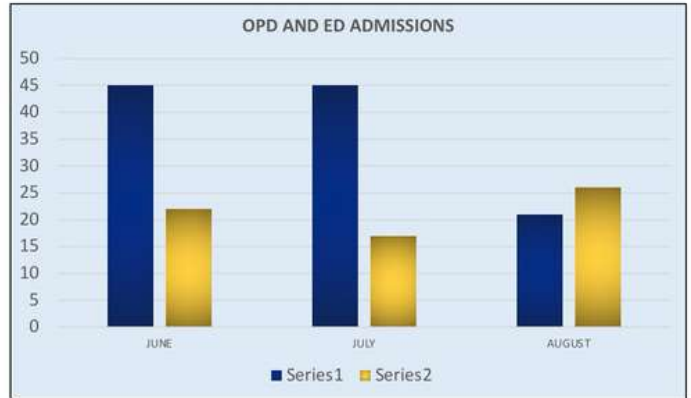
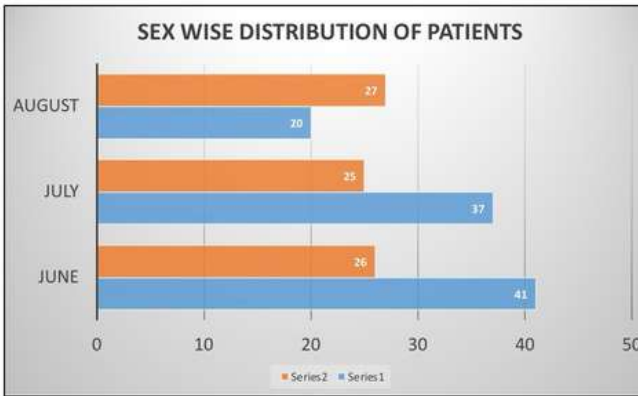
Congratulations!

The Answers were given by Dr. Mihir Vedula, M.D. Geriatric Medicine, Senior Resident, JIPMER

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JUN - AUG, 2024



The Soliloquy of an Old Man

Oh Darling! I miss you so much
 Minutes, hours and days passby
 Before Lakshman hears, what I say
 My Ram has left me
 And must I live his father's destiny?

Only Tina is my silver lining
 When comes from school
 Else I feel like on old fool
 Her laughter is my only joy
 And tele with news and astrology my only coy

The Sita of our family cares for me
 But my heart feels numb
 For I don't know how to un-numb
 I crossed for you seven sea
 Even when you made me leave
 My only girl- my true son

Oh darling! I wish I was the one
 Who went earlier, the hated one
 For you could piece together this broken family
 For you could piece together a broken me

To my Ram- I am sorry for my sins
 To my Shyam- I am sorry for my crings
 To my girl- I am sorry for the pains
 To you my darling - I am sorry for I failed
 To me- I don't know
 If I am in solitude or cage



Dr. Yatharath Malik

PHOTO GALLERY



Inauguration of the 1st issue of **SILVERLINING** by h'nble Director and Dean, AIIMS Rishikesh



Winners of intradepartmental quiz "Quizadium Leviosa", Dr. Yatharth and Dr. Anupam (Junior Residents)

Dr. Pankhuri (Junior Resident), attending the 5th International Conference of Geriatric Medicine and Gerontology, Penang, Malaysia for poster presentation.

Dr. Sudeep and Dr. Vasu, Senior Residents, attending the 5th International Conference of Geriatric Medicine and Gerontology, SilverAge 2024 in Penang, Malaysia for paper presentations. Both of them bagged the awards for best poster and paper presentations in respective categories.



Dr. Kritartha, Senior Resident, attending the 53rd Annual Conference of British Society of Gerontology, NewCastle, UK for paper presentation.



Department of Geriatric Medicine, AIIMS Rishikesh. On a get together filled with laughters and chit chats.



Sensitising and spreading awareness amongst public regarding safety of doctors and women rights as a part of the pan India protest for the "Abhaya" incident in West Bengal.

FROM EDITORIAL DESK



SEND IN YOUR SUBMISSIONS

If you know the answers to the above asked questions or you want to give a fun caption to the picture in caption contest, kindly mail us the 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



For the next issue of Newsletter our theme is "Experiences and Stories : Geriatrics through your lenses". We encourage you to send us your own stories and experiences with your older patients that you would like to share with our readers. If any older member of your family would like to share their words or experiences, then we would be delighted to include them in our newsletter.

Please send us your entries by December 1st at silverliningsaiimsrishikesh@gmail.com

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OCTOBER 2024 ISSUE

SILVER LINING

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