SLAGM

Sri Lanka Association of Geriatric Medicine

Inaugural Academic Sessions 2014

Sri Lanka Association of Geriatric Medicine

"Towards achieving a healthier and brighter silver age"

Programme and Abstracts

Inaugural Academic Sessions
Sri Lanka Association of Geriatric Medicine

PROGRAMME & ABSTRACTS

12th&13th of November - 2014
Sri Lanka Foundation

Sri Lanka Association of Geriatric Medicine

Council Members - 2014

Left to right seated: Dr. Lalith S. Wijayarahne (Council Member), Dr. Achala Balasuriya (Secretary), Dr. Selvie Perera (Patron),
Dr. Dilhar Samaraweera (President), Prof. Antoinette Perera (Council Member)
Standing: Dr. Dilanka Thilakarathna (Assistant Secretary), Dr. Barana Millawithana (Council Member), Dr. Shiromi Maduwage (Council Member),
Dr. Priyankara Jayawardena (Vice President), Dr. Aindralal Balasuriya (Treasurer)
Absent: Prof. Sarath Lekamwasam (Council Member)

Council of Sri Lanka Association of Geriatric Medicine
- 2014 -

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* Dr. Padma Gunaratne

* Dr. Antoinette Perera

* Dr. Pulani Lanerolle

* Dr. Anula Wijesundera

Message from the President of the Sri Lanka Association of Geriatric Medicine

It gives me great pleasure and pride to issue this message to the first Annual Academic Sessions of the Sri Lanka Association of Geriatric Medicine.

Managing the problems of the elderly in a rapidly ageing population is yet another challenge for Sri Lanka. We need to develop our health system to cater to the needs of the elderly in the quest to create an elderly friendly environment. Thus all our efforts are "Towards Achieving a Healthier and Brighter Silver Age" which is the theme of the sessions.

We have brought together foreign and local experts from different specialties to address you at the academic sessions on different aspects of Geriatric Medicine useful to trainees as well as doctors dealing with elderly patients.

The care of the elderly needs multidisciplinary and interdisciplinary approach. Our faculty comprises of specialists in geriatric medicine, general medicine, surgery, gynaecology, dermatology, community medicine and psychiatry adding colour and vibrancy to our academic programme.

A huge effort and commitment is needed to organize an activity of this nature. I am thankful to all the speakers, chairpersons, council, members of the organizing committee and the participants who have contributed to make this event a success. I also wish to convey my gratitude to the World Health Organization and pharmaceutical organizations that have sponsored this event.

I invite all with a sense of gratitude and compassion towards elderly to join with us at the first Annual Academic Sessions of the Sri Lanka Association of Geriatric Medicine.

Dr. Dilhar Samaraweera

Message from the Secretary of the Sri Lanka Association of Geriatric Medicine

As the Secretary to the Sri Lanka Association of Geriatric Medicine (SLAGM), it is with a great sense of pride and pleasure that I pen this message of felicitation to the book of proceedings of the first Annual Academic Session of the SLAGM. It has been less than a year since we formed the Sri Lanka Association of Geriatric Medicine and it is the allegiance of the membership that made this event a reality at this early stage of SLAGM.

At this inaugural session, we have been able to organise an invigorating academic session under the theme Towards Achieving a Brighter and Healthier Silver Age. Plenary lectures, symposia and free paper sessions are arranged in keeping with the theme in mind. I believe the Academic Sessions will be useful for our postgraduate trainees and for those who have a thirst for knowledge in the field of Geriatric Medicine and also for those who are actively involved in caring for the elderly in Sri Lanka.

I sincerely thank the Hon. Minister of Health Mr. Maithripala Sirisena for gracing the event as our Chief Guest. It is my pleasure to warmly welcome all the delegates both national and international to the first Academic Sessions and I am most grateful to Dr. Lalith Wijayaratne who spearheaded this major event for his unstinted support in organising this event. I am most privileged to have two eminent speakers from neighbouring India, Prof. A.B. Dey and Prof. Prasad Mathews who are among the leading experts in Geriatric Medicine in the SAARC Region.

Untiring efforts of the council members, members of the organising committee and postgraduate trainees in elderly medicine at the PGIM greatly contributed towards the success of the Academic Sessions. I thank them sincerely for their dedication and energetic efforts.

Finally let me extend an open invitation to all the members of the medical fraternity in Sri Lanka to join hands with SLAGM, for growing old is an inevitable reality that befall all of us, and as an organisation we aspire to enhance the quality of life of the older members of our society to the best of our ability by promoting proper attitudes towards elders in the community and by imparting knowledge among our membership regarding care of the elderly.

Have an enriching Academic Session!

A. Balasuriya

Dr.Achala Balasuriya

Message from the Patron of the Sri Lanka Association of Geriatric Medicine

Older people represent the fastest growing sector in society and the largest increase in hospital admissions.

Geriatrics is not a specialty that applies Adult Medicine, Surgery or Psychiatry to patients who have grown older. Rather, it is an interdisciplinary data based on human ageing, drawing on Biological, Clinical and Behavioural sciences to the elderly patients. This means that special knowledge and skills are needed for the management of the elderly patient. Recognizing this fact, the Ministry of Health and the Postgraduate Institute of Medicine created a Speciality Board in Elderly Medicine to train doctors in the specialty of Geriatric Medicine. The first batch of trainees has already obtained their diploma and the second batch is well on their way to holding a Diploma in Geriatric Medicine. Culturally, Sri Lankans still value our elders and place emphasis on parental authority. However, even in Sri Lankan society the place of the older person is not as strong as it used to be.

Also a large percentage of senior citizens are below the poverty line. It is the duty of the State to provide access to health care and social support so that the elderly can maintain their dignity and their independence at the twilight years of their life.

A word to the trainees who were chosen for this speciality

Healthy ageing involves recognizing that health promotion and disease prevention activities need to focus on maintaining independence, prevention of disease and disability, providing treatment to active disease as well as improving functional ability as well as quality of life in the older person, who is already having a disability. There is a need to avoid a paternalistic attitude. How often we see an old patient (with an accompanying daughter), been talked to the daughter by the Physician, as if the patient does not exist. Old people are not all old and grey and full of sleep. This is a misconception – there are senior citizens full of vitality and vigour and not fragile and delicate!

I feel privileged to write this message at the Inaugural Scientific Session of the Sri Lanka Association of Geriatric Medicine. I hope these academic sessions will strengthen your capacity to expand the frontiers of knowledge in your discipline so as to fulfill the health needs of the elderly.

C S Perera

Dr. Selvie Perera

Message from the Chairman of Specialty Board in Elderly Medicine

It is a great pleasure to send this message on the occasion of the Inaugural Academic Sessions of the Sri Lanka Association of Geriatric Medicine.

Being the Chairman of the Specialty Board in Elderly Medicine, I am personally delighted to take part in this academic event.

Sri Lanka has a fast growing ageing population. This will invariably change the nature of demands in our Health Care system, which will have to accommodate the needs of the older population. To address this increasing demand for the care of the elderly, the Postgraduate Institute of Medicine has already commenced a postgraduate Diploma in Elderly Medicine. The prospectus for the training of Specialists in Geriatric Medicine is almost finalised and we intend to commence the MD – Geriatrics training programme towards the middle of next year.

The organising committee of the Sri Lanka Association of Geriatric Medicine has put forward a vibrant academic programme covering most areas in the field of Geriatric medicine.

This congress features highly respected speakers who will share and discuss the new developments and scientific advancements in Geriatrics that will be an inspiration to the attendees.

I am confident that this scientific congress will create an excellent platform to enlighten our participants with new insights in the care of the elderly and also give an opportunity for fruitful discussions with the colleagues who care for elderly patients.

Dr. Lalith Wijayaratne

Message from the Chief guest - Minister of Health

I congratulate the Sri Lanka Association of Geriatric Medicine (SLAGM) for organizing the Inaugural Annual Academic Sessions in November 2014. Yours is a specialty that focuses on health care of the elderly people.

The theme for the conference, 'Towards achieving Brighter and Healthier Silver Age' has been appropriately chosen by SLAGM as it signifies the primary responsibility of the medical profession towards the seniors in Sri Lanka. At the Ministry level we have initiated many new programs to upgrade the healthcare facilities of the peripheral hospitals catering to the majority of the elderly population and plans have already been prepared to train health care professionals to look after the wellbeing of the ageing population.

Ageing is something common to all of us. Sri Lanka is facing a rapidly ageing population due to increase of life expectancy, and decrease of birth rate. Today we are trying to find ways and means or programmes to make the lives of aged happy and healthy. We have a number of Social security schemes in place for different categories of people to support them in their old age.

Throughout history, the cultures of the world have defined the success of people by their treatment of their elders. Family is the most important thing we can have. They are the ones we can trust, love and can depend on. Care giving is a natural occurrence in Sri Lankan culture.

Let us be realistic about old age and see it as a natural and inevitable process. This will help us to gracefully surrender the things of youth and use our energy with meaningful activities in preparation for the end.

I am confident the Academic Sessions will be a success and I convey my greetings and best wishes for the proceedings.

Hon. Maithripala Sirisena
Minister of Health, Sri Lanka

Programme

Inauguration Ceremony

Date : Wednesday 12th November 2014

Time : 6.00 p.m. to 9.00 p.m.

Venue: Sri Lanka Foundation, Colombo 07

Time	Programme
6.00 - 6.10 PM	Arrival of guests
6.10 - 6.20 PM	Arrival of the Chief Guest
6.20 - 6.30 PM	Ceremonial procession
6.30 - 6.35 PM	National Anthem
6.35 - 6.40 PM	Lighting of the oil lamp
6.40 - 6.50 PM	Welcome address by Dr. Lalith S. Wijayaratne Founder of Sri Lanka Association of Geriatric Medicine
6.50 - 7.05 PM	Address by Dr. Dilhar Samaraweera President, Sri Lanka Association of Geriatric Medicine
7.05 - 7.25 PM	Address by the **Chief Guest** Hon. Maitripala Sirisena, Minister of Health, Sri Lanka
7.25 - 7.40 PM	Address by the **Guest of Honour** Vidyajyothi Professor Rezvi Sheriff
7.40 - 7.45 PM	Special Awards
7.45 - 7.55 PM	Vote of thanks by Dr. Achala Balasuriya Honorary Secretary, Sri Lanka Association of Geriatric Medicine
7.55 - 8.15 PM	Variety entertainment by senior citizens
8.15 - 8.25 PM	Procession leaves the hall
8.25 PM	Reception

Academic Sessions

Date : Thursday 13th November 2014
Time : 7.30 a.m. to 4.45 p.m.
Venue: Sri Lanka Foundation, Colombo 07

Time	Programme
8.15 - 8.30 AM	Ceremonial Procession
8.30 - 8.35 AM	National Anthem
8.35 - 8.45 AM	Lighting of the oil lamp
8.45 - 8.50 AM	Welcome Address by President - Dr.Dilhar Samaraweera
8.50 - 10.05 AM	**Symposium 1 - Winds of change** Chairpersons - *Dr. Selvie Perera, Prof. Gita Fernando* **Brighter Aspects of life after menopause** Dr. Harsha Atapattu **Prescribing for the older patient** Prof. Prasad Mathews **Health care and beauty solutions in ageing skin** Dr. Ajith Kannangara
10.05 - 10.20 AM	**Tea**
10.20 - 10.50AM	**Plenary 1 -** Chairpersons - *Dr. M. K. Ragunathan, Dr. Achala Balasuriya* **Recent Advances in Geriatric Medicine** Dr. Raja Salgado
10.50 - 11.20 AM	**Plenary 2 -** Chairpersons - *Dr. Anula Wijesundera, Dr. Achala Balasuriya* **Comprehensive assessment of the elderly** Prof. A. B. Dey
11.20 - 12.35 PM	**Symposium 2 - Fragile, handle with care!** Chairpersons - *Prof. Colvin Gooneratne, Dr. Uditha Bulugahapitiya* **Falls in the elderly** Dr. Priyankara Jayawardena **Fractures in the elderly and management after surgery** Dr. Chandana Karunathilake **New Dimensions in the management of osteoporosis in the elderly** Prof. Sarath Lekamwasam
12.35 - 1.15 PM	**Lunch**
1.15 - 2.15 PM	**Free Papers** Chairpersons - *Dr. Aindralal Balasuriya, Dr. Ayesha Lokubalasuriya*
2.15 - 2.45 PM	**Plenary 3 -** Chairpersons - *Dr. Shehan Williams, Dr. Padma Gunaratne* **Delirium - Do we know enough?** Prof. Prasad Mathews
2.45 - 3.30 PM	**Panel discussion - Active and Healthy Ageing : What can be done at primary level?** Moderator - Dr. Ruvaiz Haniffa Dr. Shiromi Maduwage Dr. Aindralal Balasuriya Dr. Janaka Ramanayaka
3.30 - 4.00 PM	**Plenary 4 -** Chairpersons - *Dr. Antoinette Perera, Dr. Dilhar Samaraweera* **Rehabilitation of the older person** Dr. Lalith S. Wijayaratne
4.00 - 4.30 PM	**Plenary 5 -** Chairpersons - *Dr. Antoinette Perera, Dr. Pulani Lanerolle* **Ageing and Nutrition** Dr. Varsha
4.30 - 4.45 PM	Concluding Remarks - Hony. Secretary of Sri Lanka Association of Geriatric Medicine Dr. Achala Balasuriya
4.45 PM	**Tea**

FACULTY

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Dr. Ruvaiz Haniffa
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Abstracts of Invited Presentations

Brighter Aspects of Life After Menopause

Dr Harsha Atapattu.

Resident Consultant Obstetrician and Gynaecologist.

General Hospital Kaluthara.

Menopause is defined by the World Health Organization as the permanent cessation of menstruation resulting from the loss of ovarian follicular activity. A woman is considered to have attained menopause when she ceases to have periods for consecutive 12 months. With the increasing life expectancy a woman is expected to live one third of her life in the post-menopausal age group.

Menopause is associated with oestrogen deficiency and in turn it leads to many physical and psychological morbidities. These include hot flashes, osteoporosis, urinary dysfunction, genital prolapse, sexual dysfunction, cardiovascular diseases & psychological disorders.

Though the problems of oestrogen deficiency can be diverse, menopause may be a blessing for a significant proportion of women. Absence of menstrual bleeding provides them a time without the burden of being ready for it every month and to carry out day to day activities more freely. Dysmenorrhea and pre menstrual syndrome cease to trouble them anymore. Fear of pregnancy becomes a thing of past and sexual intercourse becomes more enjoyable. The incidence and discomfort due to endometriosis & fibroids gradually decline after the climacteric.

The place of the woman in this age group in the family and the society is more accepted and valued. Though they have reached menopause, the women in this age group are still young. They are more mature, wise, knowledgeable, financially stable, have more freedom and are independent. Their leadership is accepted by the others.

Menopause is an unavoidable life cycle event in any woman who lives beyond her fifties. Therefore it is a must that she gets well prepared to welcome it and have a brighter life after menopause. Lifecycle modification is a mandatory step towards this including family planning. Hormone replacement therapy is available for the ones who suffer from symptoms. Of utmost importance is, the awareness and the preparedness for a brighter post reproductive life.

Health care and beauty solutions in ageing skin

Dr Ajith Kannangara.

Consultant Dermatologist.

Base Hospital Balapitiya.

Although ageing is a fact of life, modern society has increasingly extolled a youthful appearance. Despite societal pressure, ageing is, however, a process that affects every organ of the human body and in which both intrinsic and extrinsic factors gradually leads to a loss of structural integrity and physiological function. The central nervous, cardiovascular, immune, and endocrine systems all deteriorate as we age. But now here the ageing process manifests itself more visibly than in our skin. The synergistic effects of intrinsic and extrinsic ageing factors over time promote a progressive deterioration of the cutaneous layer, which in turn, may result in significant morbidity. Aged skin is prone to dryness and itching, cutaneous infections, vascular complications, pigmentary changes and increased risk of malignancy.

Over the years there has been a dramatic reversal of our attitude towards ageing. What was earlier accepted as natural phenomenon is no longer accepted in today's world. The eternal quest for looking young has led to an exponential increase in various anti-ageing therapies, proven and unproven. The increasing in the ageing population and the psychological impact of ageing has created an enormous demand for effective modalities to rejuvenate the ageing skin. The approach to management of ageing skin should be individualized according to the skin characteristics, racial, ethnic background and psychosocial make-up. The key to successful skin rejuvenation programme involves through knowledge and skill at using medical and surgical treatment modalities effectively and judiciously.

Prescribing for the older patient

Prof. Prasad Mathews.

Consultant Geriatrician.

Christian Medical College, Vellore, India.

The elderly have an increasing number of comorbidities as they age and there is a corresponding increase in drug usage. Polypharmacy (use of 5 or more drugs) is seen in up to 30% of the elderly and excessive polypharmacy (use of 10 or more drugs) is not uncommon. Use of over the counter (OTC) medications, dietary supplements and herbal medicines is also common.

The elderly are more prone to drug side effects because of altered drug handling. Total body water is lower than in younger patients and renal function is impaired in one thirds of elderly. Serum creatinine levels do not reflect actual glomerular filtration rate (GFR) and GFR should be estimated. The MDRD equation gives a more accurate estimate of GFR in the elderly than the Cockroft Gault formula.

Polypharmacy leads to numerous problems in the elderly. Drug adherence is significantly impacted as the number of drugs ingested increases. The chance of drug-drug interactions increases exponentially with increasing drug intake as does the risk of disease drug interactions. The risk of adverse drug reactions (ADR) also increases with increasing drug use with studies showing up to 15% of hospitalizations in the elderly related to ADR.

Simple principles can help physicians to prescribe medications safely in the elderly. These principles include the following.

1. Taking a complete drug history. This involves getting the patient or relatives to bring in all the medicines including OTC's herbal medicines and dietary supplements.

2. Avoidance of polypharmacy by reviewing drug lists regularly for both out patients and inpatients and withdrawing unnecessary medicines.

3. Maintaining a list of medical problems so as to avoid drug disease interactions.

4. Use of explicit prescribing guidelines such as Beers criteria (last revised in 2012 by the American Geriatrics Society) to promote safe prescribing. Beers criteria lists three categories of drugs - drugs to be avoided in the elderly, drugs to be avoided in certain diseases and drugs to be used with caution.

5. Attempting non pharmacologic methods before prescribing a drug.

6. Identification of problems due to a drug side effect. The "prescribing cascade" in which a drug is used to treat the side effect of another drug rather than withdrawing the offending drug needs to be avoided.

7. Starting with lower doses of drugs in the elderly and increasing the dose gradually. Before increasing the dose confirmation that the patient is actually taking the medicine properly is essential.

8. Estimation of GFR and appropriate adjustment of drug dosing.

9. Use of caution is to spot and avoid drug interactions. Computerized drug prescribing programs can be helpful by providing alerts of drug interactions to physicians.

10. Use of common sense in prescribing drugs for patients who are in palliative care or have advanced dementia.

Comprehensive assessment of the elderly

Prof. A. B. Dey

Professor & Head, Department of Geriatric Medicine

All India Institute of Medical Sciences

New Delhi, India

The term 'geriatric assessment' is used to describe a clinical approach to older patients that goes beyond a traditional medical history and physical examination. Its rationale is to recognize common geriatric disorders in order to improve functional outcomes and quality of life for older adults. Geriatric assessment can be comprehensive and interdisciplinary and involve multiple team members (e.g., social services, nursing, medical, physical therapy, occupational therapy, psychology, audiology, dentistry, pharmacy, nutrition, speech therapy). Alternatively can involve just two or three informal team members and be simple in scope and approach. In outpatient practice, the evaluation can often be carried out with a fair degree of accuracy by the primary or secondary care physician perhaps with the help of a health worker. The ultimate aim of such an assessment is cost-effective use of services, keeping the patient active and providing a good quality of life. Assessment of the elderly follows the same principles of clinical evaluation as for any age group. However, while evaluating older patients several aspects (domains) are to be reviewed which are often overlooked in younger patients. The components of geriatric assessment are physical, functional, psychological (cognitive, affective), financial, social support and care facility, environmental and overall quality of life.

Evaluation and management of newly-worsened health status requires structured approach to achieve the best result. When an old patient has got new deterioration of health status or a newly discovered risk factor, a brief functional status evaluation comprised of basic activities of daily living, cognitive status evaluation and affective status evaluation is essential. In the presence of severe functional disability the patient should be hospitalized for detailed multidisciplinary assessment and management. In the presence of mild to moderate dysfunction in a stable patient, the symptoms need to be analyzed carefully for a contributing cause. When a cause has been found it should be managed, along with mobilization of care-giver support and rehabilitation in order to maximize function. However, when no cause is found, the dysfunction is managed with additional rehabilitation and care-giver support with similar results. When the functional evaluation reveals good function, the older patient needs to be reassured and advised on positive health behavior and regular screening to prevent future disability.

Early randomized clinical trials provided convincing evidence that such programs conducted in hospital-based and rehabilitation units, which typically required several weeks of treatment, could lead to better survival rates, improved functional status, and more desirable placement following discharge from the hospital. It is important to distinguish older patients who would benefit from CGA, from those who are either too sick or are too well to benefit. To date, no easily administered targeting criteria have been demonstrated and validated to readily identify patients who are likely to benefit from CGA in different settings. Specific strategies used by CGA programs to identify older persons who are most appropriate for CGA have included chronological age, functional disability, physical illness, geriatric conditions, psychosocial conditions, and previous or predicted high health care utilization. Most CGA programs exclude patients who are unlikely to benefit because of terminal illness, severe dementia, complete functional dependence, and inevitable nursing home placement. Exclusionary criteria have also included identifying older persons who are "too healthy" to benefit. In virtually all studies of CGA, the process itself has resulted in improved detection and documentation of geriatric problems. Despite unresolved issues regarding the effectiveness of CGA, the principles of CGA have been incorporated into a number of programs that have been demonstrated to be effective. Geriatric evaluation and continuity management is a direct outgrowth of CGA. These programs differ from CGA in that they become the source of ongoing primary care usually by interdisciplinary teams in geriatrics clinics.

Fractures in the elderly and management after surgery

Dr Chandana R Karunathilaka.

Resident Consultant Orthopaedic Surgeon, Accident Service,

The National Hospital of Sri Lanka.

In the elderly, age related changes occur in the musculoskeletal system. These changes are the reduction in muscle mass (sarcopenia and frailty syndrome), osteoporosis and increase fragility of bone, osteoarthritis reduce the joint mobility, associated medical problems (poor vision, hearing, neurological issues) changes in postural balance and reduce senses. They are associated with low inflammatory state with inadequate response to internal & external stresses. They have a tendency to fall and fracture.

In osteoporosis , the bone mineral density (BMD) is reduced, bone micro-architecture is disrupted, and the amount and variety of proteins in bone is altered, which results in increase fragility of bone and fracture.

Common fractures in old age are distal radius fracture, fracture neck of femur, spinal (vertebral) fractures, and humerus fractures (neck and the shaft). These fractures tend to occur with related to a specific age group which is called as tri-model pattern of fragility fractures.

Management of fragility fracture should be a holistic approach to the whole patient. The investigation profile as with Xray of the affected region, CT scan or MRI scan as required.

No absolute consensus on the best method of treatment for distal radius fractures in the elderly. This is due to lack of randomized controlled studies. In younger age the surgical fixation is better for the functional out come. The very old and frail, dependent or demented patient, benefited with simple cast immobilization. Anatomical reduction does not required in above group.

Hip fracture is the most serious consequence of fragility and frailty in old age. Approximately 15%-20% of patients die within 1 year of fracture. It is a growing problem in Asia. By 2050, more than 6.25 million will suffer osteoporotic fractures all over the world.

When the femoral head blood supply is disturbed it needs replacement of femoral head (Hemiarthroplasty / Total hip replacement). When the blood supply retain it can be fixed (extramedullary and intramedullary fixation).

Most of the vertebral fractures occur after a trivial fall. Majority of cases, the neurology is not affected and can be manage conservatively. Novel treatments include kyphoplasty of the fractured vertebrae.

Common problems associated with fragility fractures are affected mobility, reduced functional capacities such as nutrition, self care, sanitary activities, affected social & recreational activities, psychological weakness and depression.

Management of fragility fractures should be a holistic approach to the whole patient. In addition to the fracture management we have to pay attention on rehabilitation and mobilization of the patient, treatment of osteoporosis and sarcopenia, primary prevention and secondary prevention of another fall and a fracture.

Falls in the elderly

Dr Priyankara Jayawardena.

Consultant Physician.

Castle Street Hospital for Women, Colombo.

Falls are common among elderly and some people end up with recurrent falls. Falls are multi-factorial and can result due to internal factors of the body or external factors in the environment.

The main internal risk factors are effects of ageing and medical causes such as impaired sensory input, acute exacerbation of chronic disease and acute health problems. The other internal risk factors include certain drugs, gait abnormalities, reduced cerebral perfusion, epilepsy, dizziness and unsteadiness, psychiatric problems and dementia. External risk factors include poor living conditions, living in houses which need repairs, inappropriate poorly maintained furniture, defective lighting and improper bathrooms. Inappropriate walking aids, improper shoes and unfamiliar environment are the other external risk factors contributing to the falls.

Falls can result in devastating sequelae such as physical injuries, psychological injuries, social injuries and even death.

Determining the causes of falls is very important when managing falls. A proper history should be obtained which includes symptoms occurring with or prior to fall, history of previous falls, location, activity associated with fall, time of fall, history of any chronic or acute Illnesses and medications he/she is on and trauma sustained due to fall.

A complete examination must be performed giving special attention to cardiovascular system, central nervous system and musculoskeletal system.

Investigations should include basic investigations such as FBC,ESR,BU,SE,TSH, ECG etc and other special tests for the unexplained falls.

Management of falls is a multidisciplinary action. Falls are best managed in falls prevention clinics. The best management approach for falls would be identification and treatment of causes of falls and elimination of contributing factors. Physiotherapy and occupational therapy play a major role in the management. When no obvious cause is found, measures should be taken to reduce risks arising from falls. Educating the patients and relatives about safety at home and risk factors is an important aspect in the management.

New dimensions in the management of osteoporosis in the elderly

Prof. Sarath Lekamwasam

Senior Professor in Medicine

Dean Faculty of Medicine, University of Ruhuna.

Characteristically, osteoporosis is a disease of old age and osteoporosis-related fractures are predominantly seen among elderly. Apart from reduced BMD, reduced muscle mass and recurrent falls contribute to the high occurrence of fractures among them. Low calcium absorption in the gut mucosa and reduced serum vitamin D levels in old age lead to secondary hyperparathyroidism which in turn accelerates the rate of bone loss. Poor nutrition and limited physical activities are additional negative factors.

Elderly, compared to younger patients are less likely to undergo screening for osteoporosis or fracture risk. Furthermore, the FRAX model which estimates the absolute fracture risk of an individual for a given set of clinical risk factors may underestimate the fracture risk in old age.

The efficacy of mostly used drugs in osteoporosis remains uncertain among elderly. If these drugs are equally effective in old age, the number needed to treat (NNT) to prevent one fracture will be less compared to younger patients. Anti-fracture efficacy of vitamin D is mainly limited to older institutionalized elderly. Most of the drugs given for osteoporosis are well tolerated by elderly but polypharmacy and cost of drugs are major practical limitations.

Ageing and nutrition

Dr. Varsha

Consultant Clinical Nutritionist,

Indian Institute of Nutritional Sciences, Chennai, India.

Following issues would be highlighted in this presentation

1. Changes in body composition over time.
2. Factors impacting nutrition intake with aging.
3. How nutrition contributes to health status in the aged - ageing process by poorly defined mechanism; Development of non-communicable diseases [Obesity; Cardiovascular; Diabetes; Neoplastic; Degenerative joint disease; Osteoporosis and fractures] ; Nutrient and non-nutrient food factor deficiency; Immunodeficiency and, potentially, Infectious disease & Neoplastic disease.
4. Malnutrition: a vicious cycle – Its impact in the elderly population – sarcopenia & cognitive changes that result also in increased risk of infection; increased hospitalization duration; increased hospital costs.
5. Nutritional Intervention in the growing older population: Identify association between selected geriatric problems and nutrition: Sarcopenia; Weight loss; Dehydration; Swallowing; Dementia; Pressure ulcers; Constipation; Depression and
6. Strategies for the treatment of these problems
7. Role of protein & energy in Immunity & recovery; Importance of whey protein; Effects of different types of fats; Probiotics and prebiotics; Fiber vs inulin; Antioxidants; Vitamin E & A; & Fluid – nutrient comparison.
8. Results of INUS Community based studies of food intake & health in the aged
9. Value of Physical Activity In The Aged especially its relation to higher plane of energy nutrition & food component through-out.

Rehabilitation of the older person

Dr Lalith Wijayaratne.

Consultant Rheumatologist.

The National Hospital of Sri Lanka.

Disability is common among older people as it is strongly related to age. The prevalence of the common disabling conditions such as strokes, arthritis, dementia, cardiorespiratory diseases, fracture neck of the femur and peripheral vascular diseases increases with age. Successful rehabilitation lessens the impact of these disabling conditions and enables the elderly person to achieve considerable health gain.

Rehabilitation is a comprehensive treatment process usually involving health professionals of several disciplines. The main goal in rehabilitation is to improve the quality of life of the older person by making them as independent as possible in their activities of daily living especially on their mobility and self-care without the assistance of another person.

In rehabilitation the patient is an active participant rather than a passive recipient; getting actively involved in the management process.

Rehabilitation is a continuous process and needs to be continued after the patient leaves the hospital. Therefore the family members and the carers too should get actively involved with the multidisciplinary team in the rehabilitation of the older person.

Among the elderly with disability those with significant disability of recent onset have the potential to benefit from rehabilitation.

Delirium – Do we know enough?

Prof. Prasad Mathews.
Consultant Geriatrician.
Christian Medical College, Vellore, India.

Delirium is a disorder of acute onset characterised by altered consciousness (agitated or drowsy), impaired attention and cognition, fluctuating course and perceptual disturbances such as visual hallucinations. The biology of delirium is poorly understood. There is some evidence that reduced acetyl choline levels have a role to play in the pathogenesis of delirium. Delirium is a common problem in the elderly affecting up to 30% of medical in patients and 50% of surgical patients. Patients with dementia, stroke, Parkinsons disease and sensory impairment are at higher risk of delirium. Delirium is usually precipitated by an acute medical condition such as an infection or metabolic derangement, substance intoxication or drug side effect. The most common infections are sepsis, urinary, respiratory tract and skin and soft tissue infections. Hyponatremia and hypo and hyperglycemia are common metabolic derangements causing delirium. Drugs with anticholinergic activity are common causes of delirium.

Several studies have shown that multi component interventions can reduce the prevalence of delirium especially in surgical patients such as those with hip fracture. These interventions have become the standard of care and should be systematically implemented in health care facilities.

The diagnosis of delirium is clinical. Under diagnosis is common and the diagnosis may be missed in up to 70% of patients. Training of nurses and doctors improves the detection of delirium. The best and most commonly used tool for diagnosis is the confusion assessment method (CAM). The CAM has a sensitivity of 94 – 100% and specificity of 95% for the diagnosis of delirium.

Precipitating factors have to be addressed as the first step in the management of delirium. Non pharmacological methods should be used as far as possible in treating the manifestations of delirium. Drugs should be used only in cases of severe agitation where there is a risk to the patient or bystanders. The most studied drugs effective in the management of agitation in delirium are haloperidol and atypical antipsychotics such as risperidone, quetiapine and olanzepine.

More research is required into the biology of delirium.

New frontiers and recent advances in geriatric medicine

Dr. Raja Salgado.
Consultant Geriatrician,
Sydney, Australia.

Though many physical factors have been known to affect ageing, there was no explanation for how psychological factors could influence ageing. Recent work has revealed the mechanisms through which stress and mindfulness meditation causes biological changes, thereby explaining how psychological factors affect health, wellbeing and ageing. Changes occurring in the endocrine and immune system due to stress indicates a relationship between a specific psychological state (such as acute stress, or complete relaxation) and certain patterns of endocrine activity (eg Parasympathetic N.S.activity,SNS activity and Hypothalmic Pituitary Adrenocortical (HPA)activation.) Cortisol is released in response to stress and it suppresses the immune system. Chronic stress also induces a chronic and systemic state of mild inflammation

Another area of research has shown that stress can accelerate ageing whilst mindfulness meditation can slow ageing. Gall and Blackburn discovered a repeating DNA structure at the end of each chromosome in all animals and humans. These structures are called telomeres. Telomeres protect our chromosomes. Later Blackburn found an enzyme, telomerase, which is a RNA protein that adds telomeres to the chromosomes. Without telomerase telomeres diminish over time. During human ageing, as cells divide, telomere length decreases. Psychological stress and inflammation shortens telomeres.

The most central theme in neuroscience over the past 10 yrs is that of Neuroplasticity. It refers to the ability of the brain and the nervous system to reorganise its neural pathways, connections and functions. Research has found that apart from brain development from conception to first few years of life, it can also take place at any time of life. Stress causes positive neuroplastic changes, resulting in atrophy, whilst positive neuroplastic changes due to some activities such as new learning and mindfulness meditation, increase grey matter in those areas related to the experience. Daily practice of mindfulness meditation has been shown by functional MRI to improve functioning in areas related to executive functioning, memory and regulation of the stress response. It has neuroprotective effects that reduce cognitive decline related to normal ageing. The practice of mindfulness meditation was first described by the Buddha 2500 years ago as a method for developing the mind. Psychologists now use this practice in several techniques such as Cognitive behavioural therapy to treat stress related disorders such as PTSD, depression and personality disorder, which also accelerate normal ageing.

The pathological changes associated with Alzheimers Disease, such as Beta amyloid deposits commence about 20 years before clinical symptoms appear. Early diagnosis now appears to be possible using an optical method that detects beta amyloid plaques in the retina, at the time these deposits first occur in the brain. The stain used for this optical method is Curcumin, or Turmeric, which is “Kaha” in Sinhala,and “Manjalpodi” in Tamil. It is widely used in curries. What is even more interesting is that consumption of Curcumin has been shown to remove plaques from the retina. The retinal technique has the potential to also detect the response to treatment and assessment of prognosis.

Free Paper Abstracts

Profile of elderly patients at an urban family practice

Haniffa, R.[1]

Background - By the year 2031 elderly will account for 22% of the Sri Lankan population. This demographic transition coupled with the epidemiological transition is a challenge to the health system where there is no formal training for those involved in the care of the elderly.

Objectives - To describe the demographic characteristics and reasons for encounter by patients over the age of sixty years.

Method - All registered elderly (>60years) patients at the Family Practice Centre, University of Sri Jayawardenepura, who had a documented visit during the period 1/1/2009 to 31/12/2010 were included.

Results - Elderly accounted for 48.6% (n=697) of the practice registry. Females constituted 60.8% (n=424) of the registered elderly. Only 36.3% had a documented visit during the study period. The commonest presenting age group for both sexes was 60-64 years. The mean age of the clinic attendee was 71.4 and 68.2 years for male and female respectively. The commonest Reason For Encounter by ICPC Chapter was endocrine and metabolic and nutritional reasons (39.8%), followed by musculoskeletal (22%) and respiratory problems (10.3%).

Conclusion - Elderly accounted for a major component of the work load in this practice. Common Reasons For Encounter (RFE) consisted mainly of "life-style" diseases which are amenable to prevention and control. Training in primary care Geriatrics should be included in GP curricula.

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Fear and risk of falling in institutionalized elderly in the district of Colombo

Senevirathne,S.A.A., Jayalath, J.L.R., Wasalathanthri, S.

Backgorund - Falling is a major health concern in the elderly worldwide. Fear of falling is a risk factor for falling. Both increased and decreased fear lead to increased number of falls.

Objective - To assess the relationship between fear of falling and the objective risk of falling in institutionalised elders in the district of Colombo.

Methods - Hundred (male=50) institutionalized elderly men and women were studied. Baseline data were obtained using an interviewer-administered questionnaire. Fear of falling was assessed using Falls Efficacy Scale-International (FES-I). Objective risk of falling was assessed by Time Up and Go (TUG) and Four Step Squared (FSST) tests. Cognition was assessed by Mini Mental Status Examination (MMSE) score. Data were analyzed using SPSSv20.0.

Results - Mean (±SD) age, height and weight was 75.75±7.35 years, 152.53±9.63cm and 50.22±10.27kg respectively. Mean MMSE score was 25.27±4.66. 12% had a past history of fractures. Mean(±SD) score of FES-I was 24.81±8.62 out of a total of 64. Although only 26% had a high level of concern regarding falling, FSST identified 57% of subjects as multiple fallers and according to TUG test 81% were having some impairment in mobility. Score of FES-I did not have significant correlations with TUG or FSST scores in both males and females. There was a significant difference between mean scores of FES-I between males (p=0.001). However TUG test and FSST scores did not show a significant difference between them.

Conclusions - Fear of falling in institutionalised elderly men and women do not predict their true risk of falling. Although fear of falling is significantly higher in females, there is no difference in the true risk of falling in them.

Nutritional status of institutionalized elders

Saritha, K.[1], Bavany, S.[2], Chandrasekara, G.A.P.[3]

Background - Sri Lanka is part of the global phenomenon of population ageing at an unprecedented rate. Institutionalized elders are increasing due to the lack of family support and social changes. Changes in nutritional status and body composition in the ageing process affect their functionality.

Objectives - The objective of the study was to assess nutritional status, functionality and food intake of institutionalized elderly.

Methodology - A cross sectional study was conducted among 232 institutionalized elders in Jaffna district. Interviewer administrated questionnaire was used. Anthropometric measurements were taken and body composition was calculated using skinfold thickness (SFT). Functionality was determined using hand grip strength. Mini Nutritional Assessment (MNA) was used to identify the elderly at risk of malnutrition. Two day weighted diet record was used to assess the nutrient intake.

Results - Mean age was 74.8±8.8 years. There was a high prevalence of overweight (18.1%) and obesity (28.9%) and the risk of malnutrition based on MNA was (60.3%) among elderly. The fat mass of normal and undernourished individuals obtained using SFT were 27.8% and 23.9% respectively. Hand grip strength was higher among males (29.2 kg) than females (15.3 kg). Disease prevalence was hypertension (26.5%), diabetes (20.9%), heart disease (12.5%), airway obstructive disorders (12.1%), psychological disorders (9.6%) and cancer (0.4 %). The daily energy intake was higher among both males (3206 kcal) and females (2608 kcal) compared to RDA values for Sri Lankans (male-1950 kcal, female-1825 kcal).

Conclusion - The study found both undernutrition as well as overnutrition problems and high prevalence of non-communicable diseases is seen among the studied elderly. Therefore, it is necessary to develop preventive and interventional programmes to promote healthy life style focusing on the elderly regarding nutrition and physical activity which could make changes on non-communicable diseases prevalence.

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Elderly widow abuse in medical office of health area Gampaha Sri Lanka

Maduwage,S[1]

Background - Elderly population in Sri Lanka is 12% of the total population. Because of female longer life expectancy, elderly widow population tends to increase.

Objective - To identify common reasons and an intervention to prevent elderly widow abuse.

Methodology - Quasi experimental design was used. Medical Officer of Health area Gampaha was selected. Focus group discussions (FGD) were held to identify reasons on elderly widow abuse. Three each of elderly widows who are getting a monthly pension and elderly widows who are not getting monthly pension were interviewed.

For the intervention study, 36 elderly widows without pension for the intervention group (IG) and 35 for the control group (CG) were selected. Four educational sessions covering ten hours were held for the IG and four general health sessions were held for the CG.

Intervention was culture specific and carried out over six weeks. Once a month gatherings were held over three months during post intervention. Pre and post test were done.

Results - FGDs revealed that causes for elderly widow abuse were cross cutting components of active ageing. Due to an unmet need of addressing causes of promotion of active ageing, elderly widows used to spend their elderly life more demanding and more dependent.

In the intervention group, leisure time activities showed a statistically significant association (p=0.02). A statistically significant association was seen in relationship with youth (p=0.04), sharing of own feelings (p=0.05) and social contacts (p=0.01).

Conclusions - Community based interventions focusing on promotion of active ageing are useful to prevent elderly abuse among elderly widows.

[1]Consultant Community Physician, Ministry of Health

Sleeping issues of the hospitalised elderly patients

[1]**Marasinghe, C.**

Background - Patients admitted to the hospital have to adjust to a different living environment. Some of them do it well but others take time. Sleep is one of the main processes that can easily be deranged due to hospitalization. Elderly population has more sleeping difficulties that young and their sleep is more likely to be distracted by hospitalization. Good sleep is important to hasten the recovery of the presenting illness.

Objectives - This study was designed to understand the sleeping issues of the hospitalised elderly patients.

Method - Fifty patients more than 65yrs of age admitted to one of the district hospitals in New Zealand during the first 6 monts of year 2014 were recruited for the study. Those who have conditions that will directly interfear with sleep such as on going pain, difficulty in breathing, urinary frequency, diarrhoea were excluded from the study. Patients were interviwed after the second night of hospitalization. After obtaining informed consent self-administered St. Mary's Hospital Sleep Questionnaire was given to the patients to fill. This is a validated questionnaire to assess the pattrn of sleep among hospitalized patients 3. The patient's medication chart was revived to understand the use of sleep promoting medication during the hospitalization.

Results - One third of the elders admitted to the hospital did not sleep well. 50% of the patients had more than one wake ups during the night. Most common reason for night time wake up was to go to the toilet. Administration of night time medications woke up quarter of the patients and another quarter was woken up for overnight clinical observations. More than two third of patients were not on sleep promoting medications during hospitalization. Nearly half the patients had day time naps.

Conclusions - Majority of hospitalized patients are not sleeping well. Half of the patients were woken up for administration of night time medications and for night time observations. Only minority of patients were on sleep promoting medications.

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The views of elders on the impact of vision impairment and barriers to vision care in Nuwara Eliya district

Holmes,W.[1], Shajehan,R.[2], Kitnasamy,S.[2], Abeywickrama,C.[2], Arsath,Y.[3], Gnaraj,F.[4], Inbaraj,S.[5], Jayakody,G.[6]

Background - Low and middle-income countries face a growing burden of vision impairment (VI) as a result of rapid population ageing and the epidemic of diabetes. VI is by far the most common disability among older people, and is often treatable. It is important to understand older people's views and experiences to develop policies to address this challenge.

Objective - To explore the impact of VI and barriers to care among older people in the Better Vision Healthy Ageing Program area of Nuwara Eliya district.

Methods - 12 focus group discussions (FGDs) were conducted with a total of 102 older men and women. Transcripts were transcribed, translated and thematically analysed.

Results - Good vision has great significance to these elders: "We need vision to do anything. It is useless to live without vision. Vision is the most important thing in life." Those with poor vision described how it restricts their lives: "We can't go here and there. We have to be only on the bed. We regret our life." They feared becoming dependent. Difficulties in carrying out domestic tasks and reading were often mentioned, and their inability to contribute to their families. Elders talked about how VI restricts participation in social and religious activities, and their ability to look after their health. They feel vulnerable: "We may fall down when we walk on the road, and we may get hit by a vehicle." The first barrier to seeking vision care was the cost; elders were reluctant to ask their children for money. Other problems were lack of information about where to seek care, long waiting times, and fear of surgery. Transport difficulties include cost, inability to stand on the bus and long waits for buses. Several suggested that eye care services should be delivered closer to their homes.

Conclusions - Our findings highlight the varied impacts of VI on elders and their families and the need to address the barriers to seeking vision care.

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Perception and satisfaction of elderly cancer patients on care services available for the elders at National Cancer Institute, Maharagama

Samarutilake,G.D.N.[1], Gunatunga,M.W.[2]

Background - Sri Lanka has the fastest ageing population in South Asia. Malignancies are essentially a common occurrence in elderly populations.

Objectives - To describe perception and satisfaction of elders on caner care services available at National Cancer Institute, Maharagama (NICM).

Methods - A cross sectional descriptive study was conducted among elderly cancer patients who have had treatments for six months or more. Interviewer administered questionnaire was used to assess satisfaction about the commonly utilized facilities and perceptions of elders on expected service improvements.

Results - Of the 306 elders sampled, 43.5% were male, 72% currently married, 70% had no income, 40% had education below grade 5 and 78.1% were cared only by their children. More than 74% were satisfied with the help of junior staff but satisfaction with waiting time and facilities available at clinics, wards, laboratory, radiology department and dispensary ranged from 14% to 34%. Majority expect separate wards (97.1%), specially trained staff (91.5%) and more welfare services (97.4%). Support of children for financial support, sufficient vision and sufficient hearing significantly predicted the need of separate wards for the elders; satisfaction about the facilities at clinics, wards, laboratory, radiology department, dispensary and waiting time at dispensary predicted the need of specially trained staff to care elders; satisfaction about the waiting time at clinics, wards, laboratory, dispensary and facilities at dispensary predicted the requirement of more welfare for the elderly cancer patients.

Conclusions - Majority of the elders was dependent on their children and was not satisfied with facilities provided and on waiting time to obtain services at NICM. Specially trained staff to care elderly cancer patients, more welfare services and separate wards for the elders emerged as priorities. Development of infrastructure facilities to cater to the needs of the elders with productive administrative improvements and human resource development are recommended.

Key words - Cancers in elderly, perception and satisfaction, cancer care services

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