

Time for Action

This month we had third annual conference of the Indian Academy of Geriatrics at Trivandrum. We acknowledge the efforts put in by Dr D Dalus and his team in organizing the event. It provided an excellent opportunity to discuss various burning issues about the geriatric care in our country. Theme of the conference was "Healthy Ageing". The way a person ages depends upon gender, socio-economic determinants, physical environment, personal and behavioral factors and availability of health and social services. Active ageing is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age. In order to promote active ageing, health systems need to take a life course perspective that focuses on health promotion, disease prevention and equitable access to quality primary health care and long-term care. Elderly people need to be provided with comprehensive health care addressing physical, mental and social problems. I am hopeful the deliberations during the conference will be translated into action at national level. The Government of India has also recognized the need for the health care of elderly. A national programme for the geriatric care would be appropriate at this moment. Now is the time for action, lest the sheer number of elderly in our country overwhelm the health services.

Cardiovascular diseases are the primary cause of death in elderly. Cardiovascular health is an important determinant of successful aging. In the present issue V Makkada et al have audited the use of anticoagulants in elderly patients with atrial fibrillation (AF) in Middlemore Hospital, Auckland. They have reported under prescription of anti coagulants even in high stroke risk patients with AF.¹ Nonvalvular atrial fibrillation is an independent risk factor for stroke that becomes increasingly prevalent as populations age. Clinical trials have shown that long term anticoagulation reduces the risk of stroke associated with atrial fibrillation, but warfarin is taken by only 30-60% of appropriate patients.^{2,3} The narrow therapeutic index of warfarin requires that the intensity of anticoagulation be maintained within the international normalized ratio (INR) range of 2.0 to 3.0 to optimize efficacy while minimizing bleeding risk. The pharmacokinetics of

warfarin are subject to variability due to interactions with multiple drugs and foods, making maintenance of the INR within this range difficult to achieve in clinical practice without close coagulation monitoring and frequent dose adjustments. Current guidelines recommend oral anticoagulation for high risk individuals with AF but these inherent limitations lead to substantial underprescribing, particularly in elderly patients, as about 15% of all strokes are attributable to atrial fibrillation, the clinical and economic consequences of underprescription of warfarin are profound.⁴ Physician's overestimation of the risks of anticoagulation is the most consistently cited explanation for the observed patterns of warfarin use.⁵ These perceptions may be influenced by physician's experiences with warfarin use in their patients; physicians whose patients have had adverse events from anticoagulation may be less likely to prescribe warfarin. Adverse events associated with an action (for instance, a major haemorrhage in a patient with atrial fibrillation who had been prescribed warfarin) may have more influence on a physician's practice than adverse events associated with inaction (for instance, not prescribing warfarin to a patient with atrial fibrillation who subsequently has a thromboembolic stroke).

Congestive heart failure (CHF) is one of the main reason of death and physical disability in elderly. Today ACE inhibitors, beta-blockers, diuretics are the first line drugs in treatment of CHF. Drugs optimizing cardiac energy metabolism have raised great interest recently. Partial fatty acid oxidation inhibitors shift fatty acid oxidation to glucose oxidation leading to a reduced gluconeogenesis and improved economy of cardiac work.

Mildronate (3-(2,2,2-trimethylhydrazinium) propionate; MET-88; meldonium, quaterine) is an antiischemic drug developed at the Latvian Institute of Organic Synthesis.⁶ Mildronate was designed to inhibit carnitine biosynthesis in order to prevent accumulation of cytotoxic intermediate products of fatty acid beta-oxidation in ischemic tissues and to block this highly oxygen consuming process. Besides this there is an alternative, non carnitine dependent mechanism of action of mildronate.

Mildronate is efficient in the treatment of heart ischemia and its consequences. Mildronate has also shown to have beneficial effect on cerebral circulation disorders and central nervous system functions. Audris Visokinskas et al studied the use of mildronate in geriatric patients with CHF, finding it a useful drug to complement the therapy.⁷ Whether the drug will prove to effect morbidity and mortality due to the disease remains to be seen.

Ageing and improving survival of patients with coronary heart disease are responsible for an increase in number of older adults eligible for cardiac rehabilitation. The elderly with coronary heart disease represent a special population with changes induced by ageing and lifestyle, comorbidities, cognitive dysfunction, and high risk of disability. Although the elderly account for the majority of cardiac admissions and procedures, studies on cardiac rehabilitation have traditionally focused on younger patients.

In older patients also, exercise improves functional capacity and reduces myocardial work similar to that seen in younger patients. In elderly patients cardiac rehabilitation requires a multidisciplinary approach including comprehensive assessment, treatment of risk factors and comorbidities and psychosocial assessment. Cardiac rehabilitation is safe and helpful for elderly coronary patients. Physicians must be encouraged to prescribe cardiac rehabilitation programme for the elderly following major coronary events and coronary revascularization procedures.⁸ Pawar R B et al have found a hospital based cardiac rehabilitation exercise program more inexpensive and effective method to modify coronary risk factors and improve functional capacity in patients with stable coronary heart disease.⁹ In an ageing population, physical training aims at maintaining skeletal muscle force and muscle mass as well as locomotor coordination. Ultimately, the goal is to reduce the substantial morbidity among elderly due to coronary artery disease.

Chakarvaty BP et al evaluated new onset dyspepsia in elderly with endoscopic examination and detected significant pathology in 80% of the patients.¹⁰ Dyspepsia is a common problem in elderly patients. Endoscopic examination of all patients with dyspepsia is hard to perform, because of high prevalence of dyspepsia and limited resource availability. However patients with new onset of dyspepsia in elderly age group or patients

with "alarm" features at presentation like dysphagia, weight loss, gastrointestinal bleeding, anaemia, vomiting, history of gastric surgery and history of peptic ulcer disease should have endoscopic evaluation.

Sharma MK et al have gathered life styles and morbidity profile of geriatric population in urban areas of Chandigarh.¹¹ These data are essential for the planning of health care programmes.

There are so many other issues to be discussed and shared. We look forward for active contribution from our readers.

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Editor

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