# SLAGM NEWS

*Official Newsletter of the*
*Sri Lankan Association of Geriatric Medicine*
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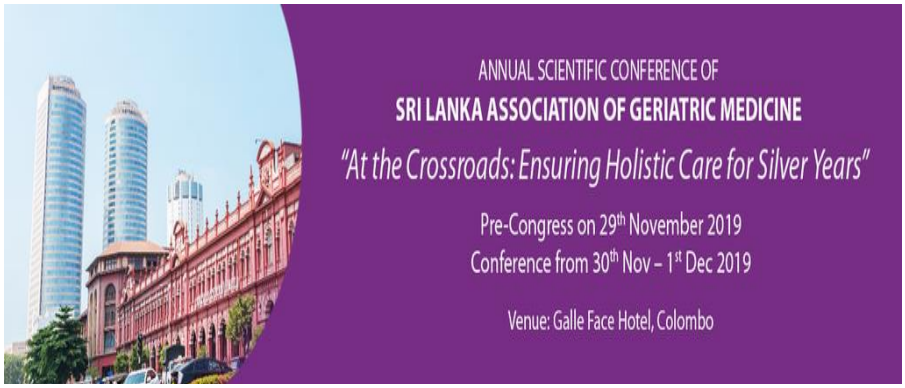
## *Words from the President*

*Dear Colleagues and Friends…….*Read more

**Wedihiti Diviyata Athwelak (An Aid for Healthy Ageing) at SLFI 2019**




***1st November 2019***
***Current Issue***



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# *Words from the President*

*Dear Colleagues and Friends,*

I welcome you all to the second newsletter of the SLAGM! In this issue I wish to emphasize the commitment of the SLAGM towards the "Holistic Care" for the older people, and as we endeavor to embark on this journey, we need to recognize the importance of teamwork in the form of Multidisciplinary Care (MDT).

Worldwide elderly population is rising. It is even more relevant to Sri Lanka, as Sri Lanka is one of the fastest ageing countries in the region. The percentage of population over 60 years was 12% in 2012 and 15% in 2015 and it is predicted to rise up to 29% by 2050. It is estimated that the aged more than 80, will account for more than 5% by 2050.

What is ageing? Biological ageing involves wide variety of molecular and cellular damage leading to decrease in physiological reserve. Organs and systems of the body become increasingly vulnerable to diseases and over time, and eventually the death of the individual occurs. However, there is a wide variation in the rate of this process among individuals. While some become feeble at younger age, others, continue to live healthy even up to 100 years. The rate of biological changes of tissue are determined by many factors including genetics, environmental and long-term behaviour of the individual.

What is important for older person is healthy ageing. Older population with "healthy ageing" is indeed a resource for a country. There is a pressing need to improve the health care delivery system addressing the health needs of older population if they are to be used as a worthy resource for the country.

There is a wide variation with regard to capacity for activities among elders. Based on capacity, elderly period could be divided in to three phases: high and stable capacity, declining capacity and those with significant loss of capacity. During the high and stable capacity period, capacity-enhancing behavior should be promoted, with attention on prevention and early detection of chronic conditions common among older people. During the declining capacity period, focus should be on slowing the capacity decline or reversing the losses. Removing barriers for participation and trying to compensate for lost capacity become important during this period. In the face of significant loss of capacity, older person should be ensured a dignified late life.

It is important to note that older people may present to their health care providers with one single complain but in fact they may habour multiple co-morbidities with them. In evaluating their problems apart from the direct medical complaints, they should be assessed for functional disabilities. Most common disabilities that are seen among older people are impairments in vision and hearing, problems with mobility, difficulties in attending to activities of daily living, bladder and bowel control issues, cognitive

impairment, depression, social isolation and sleep problems. As all of these problems cannot be sorted out by the medical officer attending to the patient, we need a team of people to care for these older people. Thus, comes the need of the multidisciplinary team (MDT) which consist of doctors, nurses, physiotherapists, occupational therapists, speech and language therapists, social service officers and counsellors. MDT care is the most effective form of care required to treat a sick older person.

While conducting numerous academic workshops to emphasize the value of establishing multidisciplinary team care in Government Hospitals, Sri Lankan Association of Geriatric Medicine has been constantly pressurizing the Ministry of Health to implement the MDT care for older people. SLAGM organized a media conference to mark the International Day of Older Persons in 2019 under the theme, "Multidisciplinary team care for holistic approach for older persons". Let us continue to educate all concerned that 'Teamwork divides the task and multiplies the successes.

Dr. Padma Gunaratne
MD (SL), FRCP (Edin, Glasg, Lond), FCCP, Hon FRACP, FAAN, FWSO
President
Sri Lankan Association of Geriatric Medicine

# Council photo 2019/20

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## Annual General Meeting 1st July 2019

Annual General Meeting (AGM) of the SLAGM was held on the 1st of July 2019 at the SLMA auditorium. Meeting was attended by a large number of members of the SLAGM among whom were founder of the SLAGM Dr. Lalith Wijeratne and the past president, Dr. Dilhar Samaraweera. Dr. Chamila Guneratne, Secretary of SLAGM presented annual report for 2018 and Dr. Sajeewana Amerasingha presented the annual financial report for the year 2018/2019. Dr. Padama Gunaratne addressed the gathering and spoke about the progress of the Association over the last year and she thanked the council and all the members of the SLAGM who helped to achieve many milestones for the Association. As per the constitution of the SLAGM Dr. Padma Guneratne was re-elected as the president of the Association and a new council was elected. Prof. Sarath Lekamwasam was nominated as the President elect for 2020.

The first newsletter of the Association was launched at the AGM. Dr.Achala Balasuriya handed over the first copy of the newsletter to Dr. Padma Guneratne.

## Annual General Meeting of SLAGM

**Dr.Padma Guneratne addressing the AGM**


**Launching the first newsletter of SLAGM**

**Members at the AGM**

# SLAGM Articles

## Expose Unexposed Facts on Promotion of Active Healthy Ageing

***Dr. Shiromi Maduwage, Consultant Community Physician, Youth Elderly and Disability unit, Ministry of Health, Nutrition and Indigenous Medicine.***

Sri Lanka is one amongst many countries in the world with a fast ageing population. According to 2012 Census &Housing report of the country, elderly population was 12.4% out of Sri Lankan total population. From 1981 to 2012 the proportion of population aged 60 years and above has increased from 6.6% to 12.4%. It is reported that one in every four persons will be an elder by the year 2041.

According to the projections, the share of the population aged 60 years and above will increase from its current proportion of 12% up to 16% by 2020 and 29% by 2050, before peaking at 34% by 2080 (Elderly Health Policy Sri Lanka). Increasing life expectancy at birth for females is reported 78 years and for males 72 years. Reduction in mortality rates & birth rates and increasing in life expectancy rates have become some of the major contributory factors for increasing elderly population in the country.

Active healthy ageing is enabling the elderly to enjoy a good quality healthy life. Healthy ageing strategies should create the conditions and opportunities for the elderly to have active lifestyle including regular physical activity, healthy diets, social relations, participation and financial security etc. It involves holistic approaches that address both mental and physical health.

Though it is active healthy ageing, health alone cannot achieve active healthy ageing outcomes as there are many crosscutting areas to improve the socio economical determinants of health. Implementation of activities for an active healthy ageing need a multi-sectorial, multi-disciplinary approach. Active healthy life in the old age cannot be achieved in one instance or in one initiation. It is a process to be achieved throughout life which starts during pregnancy even before delivery of a newborn. Different stages in life have different roles and responsibilities to play in different settings towards a common goal, which is to achieve an active healthy life in old age.

Pregnant mothers need to be physically & mentally healthy to have a healthy newborn. Lactating mothers need to practice breast feeding including exclusive breast feeding. School children, adolescents, youth& adults need to focus on prevention of non-communicable diseases, practicing healthy life styles& maintaining mental wellbeing. Ultimately all these good healthy life style leads community towards active healthy elders in later life. Present days most of us aware what should be done to prevent non communicable diseases like diabetics, hypertension, cancers etc. and how to practice healthy life styles. Modifiable risk factors are well identified to prevent non communicable diseases. Facilities are available both at institutional & community level including screening for non-communicable diseases.

At the same time country has free health services in state sector and well established community health care system. Literacy rate is high among people. Multi stakeholder groups including state sector, private sector, on-governmental organizations conduct many advocacy and awareness programmes all around the country at different settings including schools, workplaces & community. Life course approach towards active healthy ageing is well defined.

Irrespective of all these positive remarks, unfortunately when we go through elderly health statistics, it is clear that non communicable diseases are common among the elderly. It is well evident in the Demographic Health Survey 2016 report. It is stated that 52.8% of males and 52.1% of females aged 60 years and above were suffering from heart diseases and 43.8% of elderly males & 48.6% of elderly females were suffering from diabetes in the society. Non communicable diseases are chronic diseases which need long-term treatment and their complications may be multiple. According to the Sri Lanka Population and Housing Census of 2012, over half of older persons had physical or mental impairments and about one fifth had difficulty in seeing and walking. Sixty percent of the oldest old persons had experienced at least one disability. Therefore, it is worth to review this mismatch, especially to identify the gap.

Consumption of appropriate food with proper amount has become more challengeable for the general community with their busy schedules and commercialization. When considering appropriate amounts sometime dietary advices are given in grams or servings. This may cause confusion among consumers and it may be a cause for not following dietary advices. When considering serving sizes always follow practical ways of household measurements for easy practicing methods like one tea cup of cooked rice (200ml cup) equals one serving and one slice of bread (a 500g loaf cut into 9 slices) equals one serving. Always advices need to be simple practical and easy to practice.

Behavioral changes of different target groups towards active healthy ageing need to be focused more. To achieve better behavioral changes among different

target groups, the service provider needs to identify specific behavioral objectives which he/she is going to achieve from the specific target group or service user. In many instances, without identifying the specific behavioral objective or without specifically identifying the need or a desire of a service user, many service providers launch programs or projects expecting better outcomes. Irrespective of their knowledge, some service providers act blindly due to their poor attitudes, values, practices etc., ignoring the needs of the service user. To bridge the gap, the service provider should know the gap. To know the gap, the service provider should study the situation, listen to service users and connect to the service user. Today the gap between service user and service provider through communication is very wide. In many instances we see that the service provider tries to change behavior either through printing of T-shirts, printing of caps or developing a video instead of identifying service user need.

It is difficult to achieve behavioral change among service users, but it is more difficult to maintain achieved behavioral change as a habit. Once service users achieve a healthy behavioral change, they need to be rewarded. Appreciation or rewarding is remote in the current Sri Lankan society. This should start from home. Parents need to appreciate their siblings for achieving better behaviors and values. Unfortunately today instead of appreciating their own child, comparison of children has become the current practice among many parents in the society. Such mal practices affect the better attitudes and behavioral change among children leading to poor caring of elders.

Elderly care service providers need to develop knowledge, expertise, trust, empathy and skills to handle late adaptors of service users. Trained, capable service providers need to be given better working environment which is very remote in many working settings. Therefore, monitoring, evaluation and revival need to be strengthened in all aspects including administration, especially at service provider level.

The world has identified the talents and contribution of elders to the society. It is appreciable that we Sri Lankans too have implemented this strategy to a certain extent. But it needs to be done in a wider manner and in a systematic way. This will enable our young generations to develop their values and good attitudes towards elders, and at the same time the elders get an added advantage of mental satisfaction. Our grandparents are the foundation of a family but we always need to treat them with care, dignity and love.

Ancient Sri Lankan family system was an extended family system. Currently it is shifted to nuclear family system. Present days within the nuclear family system the harmony, family bond, understanding and respecting to each other are going away. Individuals are isolated within their own world with accumulated stresses. Ultimate outcome is increased prevalence

of mental illnesses in the community. Endless competition for survival in schools, working places and in the community are commonly seen everywhere. Time has come to see prevailing problems in the modern Sri Lankan society as challenges and act accordingly to promote mental wellbeing of the community towards Active Healthy ageing. There is a popular saying ***"The happiest people don't have the best of everything; they just make the best of everything from what they have".*** So, think and act positively. Master coping skills. Treat everyone with kindness. Don't hold grudges. Avoid social comparison. Be flexible and accept what cannot be changed. Always have a hobby or engaged in a recreational activity.

A common fact that most currently most of the adult children are facing how to cope & balance their dual responsibilities of looking after old parents or grandparents while balancing day-to-day responsibilities of their own children & occupation. One might see that our children are not looking after elderly parents. But majority of them do care for their parents. Our tradition and culture provide an additional influence as well. To provide a supportive environment for the children especially for the working adults, some services & facilities for elderly care need to be strengthened soon. Services like long term care, intermediate care, day centers and availability of trained care givers have become an unmet need in the country.

Planning old age in advance is an essential component in active healthy ageing at individual level which minimizes the dependency and elder abuse. It has to be started during early stages of life.

Life becomes beautiful when lived with some purpose and still more glorious if that purpose is to make a difference in a productive way. Therefore plan your old age, maintain your dignity, add positive attitudes, be flexible, be with your family and be a resource to your younger generation

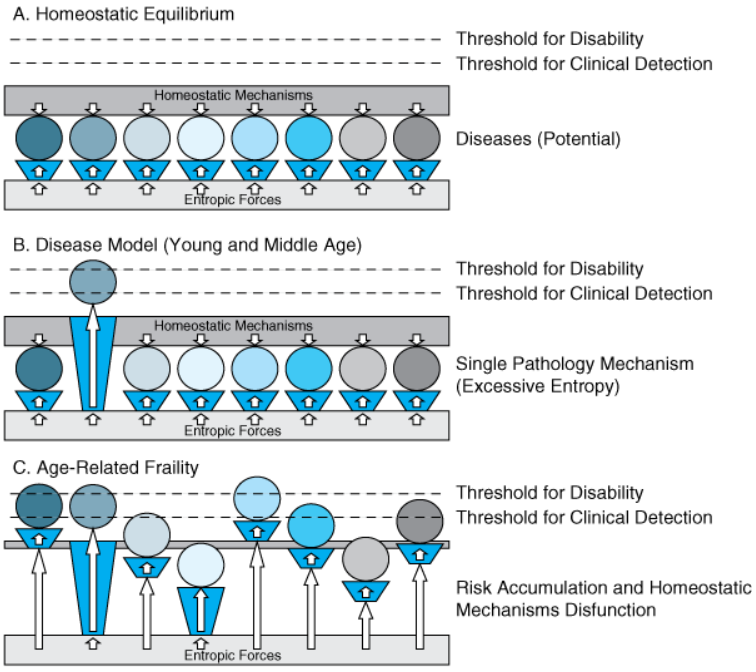
# Life starts at age 60 years

## An Overview of Frailty

***Dr. Sithira Senevirtane, Registrar in Geriatric Medicine, NHSL, Colombo***

With the rapid demographic transition in Sri Lanka, care for elderly has become a field of paramount importance. When considering the "elders "who need assistance it seems that the amount of disabilities and level of dependence are far more important factors than the sole chronological age.

Thus it is essential to look for a parameter capable of measuring the biological age than chronological age of an individual. The concept of frailty fills this gap and has become the main predictor of functional dependence in the elderly.




Source: Halter JB, Ouslander JG, Tinetti ME, Studenski S, High KP, Asthana S: *Hazzard's Geriatric Medicine and Gerontology, 6th Edition*: http://www.accessmedicine.com



Frailty is defined as a medical syndrome with multiple causes and contributors that is characterized by diminished strength, endurance, and reduced physiologic function that increases an individual's vulnerability for developing increased dependency and/or death [1].

A hallmark of frailty is the reduction of the organism's homeostatic reserves. When the homeostatic reserves are less individuals lack the capacity to handle entropic forces (from endogenous and exogenous sources) exposing them to an increased risk of negative health-related events, including falls, hospitalizations, worsening disability, institutionalization, and mortality [2,3]. In a frail individual, a relatively minor endogenous or exogenous stressor may become the trigger for the initiation of a disabling cascade of events [4].

Although the theoretical foundations of frailty are well established and largely agreed, controversies exist about its assessment. Two commonly used instruments for measuring frailty are the frailty index and the frailty phenotype. The frailty index was proposed by Rockwood and associates and was initially validated in the Canadian Study of Health and Aging [5]. This instrument is designed to measure the age-related deficit accumulation using a mathematical approach. It is the ratio between the number of deficits that a person experiences (e.g., signs, symptoms, diseases, disabilities) and the total number of deficits considered (e.g., someone with 15 deficits out of 30 counted has a frailty index score of 20/40 = 0.5). In this way, the frailty index score is continuous measurement , ranging from 0 to 1.The items in a frailty index can be variable. Generally at least 20 items should be used to create a frailty index [6]. Using the above principle one can calculate frailty in a pre-existing data set as the items are not pre-determined. The need of at least 20 items to calculate frailty index makes it a less practical method to use as a bed side screening tool in clinical practice.

Regardless of the nature and number of items included and regardless of the setting which included community, institutionalized, or hospitalized older adults, frailty index has been shown to have similar measurement properties [7].

The frailty phenotype was designed by Fried and colleagues and was initially validated in the Cardiovascular Health Study[8]. It is based on the evaluation of five core criteria which included involuntary weight loss, self-reported exhaustion, slow gait speed, muscle weakness, and sedentary behavior. The self-reported exhaustion is measured using center for epidemiological studies depression scale, while muscle weakness by measuring hand grip using a dynamometer and sedentary behavior using Minnesota leisure activity scale. The phenotype distinguishes three states of frailty which are robustness (defined as the absence of criteria), pre-frailty (presence of one or two criteria), and frailty (when three or more criteria are present).

The frailty phenotype finds its best application in non-disabled older persons. Frailty phenotype is based on signs and symptoms and provide a simple way to identify individuals who need a comprehensive geriatric assessment which can therefore be used as a bedside screening tool. A major limitation of frailty phenotype is that it’s not being informative about the potential causes of the condition of interest. For example, the involuntary weight loss in a elderly patient might be due to poor socioeconomic factors, unknown diseases or poor nutritional practices due to unawareness with different causes requiring different interventions.

In addition to frailty index and frailty phenotype, there are a number of other indicators. Some of the assessment methods of frailty include clinical FRAIL scale, PRISMA 7 tool, Edmonton frail scale, Tilburg frailty index and physical performance measures such as short physical performance battery (SPPB), timed up and go(TUG) test and gait speed.

The predictive value of physical performance measures for negative outcomes in older adults is well established[9,10].The SPPB was developed by Guralnik and coworkers to measure lower extremity function and composed of three subtests evaluating usual gait speed, ability to rise from a chair, and standing balance. TUG is another tool that used to screen for frailty.

Screening for frailty is a skill that should be developed by all the health care professionals who deal with older patients. Frailty is often a symptom and detection of frailty is a opportunity to further evaluate using comprehensive geriatric assessment. Frail elderly with loss of weight, fatigue should be screened for reversible causes. Frail individuals are more at risk of medication side effects and may require the need of de prescribing and allows the clinicians to weigh up the potential benefits and harm of treatment. Shared decision making between healthcare professionals, older adults, and their families is needed to develop a proper management plan. Practical recommendations for lifestyle modification paying special attention to incorporation of resistance training and adequate protein intake, correcting reversible causes, providing education to patients and care givers can be done to improve frailty [11].

Diagnosing frail individuals will potentiate the clinician to practice person centered realistic medicine to achieve the best outcome while avoiding unnecessary harm.

References


1. Morley JE, Vellas B, van Kan GA, Anker SD, Bauer JM, Bernabei R, et al. Frailty consensus: a call to action. J Am Med Dir Assoc. 2013;14(6):392–397.
2. Fried LP, Walston JD, Ferrucci L: Frailty. In :Halter JB, Ouslander JG, Tinetti ME, et al, editors: Hazzard's geriatric medicine and gerontology, New York, 2009, McGraw-Hill,631–645
3. Rodríguez-Mañas L, Féart C, Mann G, Vina J, Chatterji S, Chodzko-Zajiko W, et al. Searching for an operational definition of frailty: a Delphi method based consensus statement. the frailty operative definition-consensus conference project. J Gerontol A Biol Sci Med Sci 2012, 68:62–67.
4. Fried LP, Walston J: Frailty and failure to thrive. In: Hazzard WR, Blass JP, Ettinger WH, et al, editors: Principles of geriatric medicine and gerontology, New York, McGraw-Hill, 1998, 1387–1402.
5. Mitnitski A, Mogilner A, Rockwood K: The accumulation of deficits as a proxy measure of aging. Scientific world journal, 2001 Aug 8;1:323–336.
6. Searle SD, Mitnitski A, Gahbauer EA, Thomas MG, Kenneth R, A standard procedure for creating a frailty index. BMC Geriatr, 2008, 5-24.
7. Howard MF, Kenneth R, John Y. Brockelhurst'sText book of geriatric medicine and gerontology, 9th edition, Philadelphia, elsevier, 2017, 84.
8. Fried LP, Tangen CM, Walston J, Newman AB, Hirsch C, Gottdiener J, et al. Frailty in older adults: evidence for a phenotype. J Gerontol A Biol Sci Med Sci, 2001, 146-156.
9. Guralnik JM, Ferrucci L, Simonsick EM, Salive ME, Wallace RB, et al: Lower-extremity function in persons over the age of 70 years as a predictor of subsequent disability. N Engl J Med,1995, 556–561.
10. Guralnik JM, Ferrucci L, Pieper CF, Suzanne GL, Kyriakos SM, Glenn VO, et al. Lower extremity function and subsequent disability: consistency across studies, predictive models, and value of gait speed alone compared with the short physical performance battery. J Gerontol A Biol Sci Med Sci 55:2000, 221-225.
11. Elsa D, Christoper L, Wee SL, Wei CW, Chek HW, Tze PN, et al. The Asia-Pacific Clinical Practice Guidelines for the Management of Frailty, JAMDA 18, 2017, 564 – 575.

# "*Wedihiti Diviyata Athwelak*"(An Aid for Healthy Ageing)

A program to educate the health care professionals caring for the older people was launched by the SLAGM under the patronage of the President Dr. Padma Guneratne. The program was implemented for two batches at the Sri Lanka Foundation Institute and was a huge success. It was attended by large number of medical officers working in the government hospitals and private sector. The main purpose of this program is to sensitize the medical doctors to the early detection and prevention of common diseases among older people. The inaugural program which was held at SLFI on the 7th of August was attended by the Secretary to the Ministry of Health Mrs. Wasantha Perera, Director of Youth Elderly and Disabled at the Ministry of Health, Dr..Deepa Samaranayake and Dr. Shiromi Maduwage Consultant Community Physician from the Youth Elderly and Disabled Unit of the Ministry of Health.

**Aid to Healthy Ageing Programme**

**Ageing Issues in Sri Lanka**
*Dr. Aiendralal Balasooriya Consultant Community Physician*
**Early detection and prevention of common respiratory disorders in older people**
*Dr. Wathsala Gunasinghe, Consultant Respiratory Physician*
**Early detection and prevention of NCD in Older people**
*Dr. B.Thamotharan, Resident Physician*
**Early detection and prevention of cancers in older people**
*Dr. Yasantha Ariyaratne, Consultant Oncologists*
**Early detection and prevention of Psychiatry disorders in older people**
*Dr. Chathurie Suraweera, Senior Lecturer in Psychiatry*
**Early detection and prevention of Musculoskeletal Disorders in older people**
*Dr. Gunandrika Kasturirathne, Consultant Rheumatologist*
**Early detection and prevention of Falls in older people**
*Dr. Chandana Kanakarathna, Consultant in Geriatric Medicine*
**Early detection and prevention of Vision disorders in older people**
*Dr.Deepani Wewelwala, Consultant Eye Surgeon*
**Early detection and prevention of hearing disorders in older people**
*Dr. Chandra Jayasooriya, Consultant ENT Surgeon*
E**arly detection and prevention of nutrition related disorders in older people**
*Dr. Renuka Jayathissa Consultant Community Physician*
***Medical Check ups for older people***
*Dr. Ruviz Haniffa Consultant Family Physician*
**Communication Skill Development Workshop**
Dr. Asanthi Balapitiya, Consultant Community Physician

## *Programme Highlights*

**Sri Lankan Association of Geriatric Medicine is a Non- Governmental Organization registered at the National Secretariat for Non-Governmental Organizations in Sri Lanka.**

# SLAGM Publications

**"*Wedihiti Diviyata Athwelak*"** is a WHO funded TOT for medical practitioners on prevention and early detection of diseases commonly seen among older people. The programme addresses topics such as NCD, falls, respiratory disorders, hearing and vision impairment, nutrition, psychiatry disorders, medical check-ups and activities for daily living in relation to ageing. Resource persons have been nominated by the respective professional colleges. Trained medical professionals will be awarded with certificates, manual and the CDs of presentations. Trained medical professionals are encouraged to address Elder Societies in villages, country wide.

Sri Lankan Association of Geriatric Medicine published a booklet in parallel with the "An Aid to Healthy Ageing" education program.

# Towards Healthy Ageing….

Active Healthy Ageing is the key to longevity. The family physician should guide all his/her elderly patients on Active Healthy Ageing. He/she should carry out regular check-ups for elders. The best opportunity for such check-ups is when elders with ailments present themselves to the physician. Check-ups have to be individualized.

The elderly probably do not need routine screening for diseases unless they are in a vulnerable category such as being immune compromised.

The objective of the check-up is to learn the "Current Health Status" and not for diagnosis purposes. Routinely, the elderly should be assessed using ADL and IADL for functional independence and for risk factors for the Current Health Status. Our aim should be to identify the problems early and implement the necessary interventions to maintain their mobility and independence in ADL to the maximum level.

Checklist for assessment of the elderly:

- Mental state – Confusion, dementia, depression and bereavement.
- Eyes – Visual acuity, cataract and glaucoma.
- Ears – Deafness, tinnitus and vertigo.
- Mouth – Dentition, xerostomia, swallowing and malnutrition (under-nutrition in particular).
- Skin/hair/nails – Wrinkles, elastosis, eczema, pruritis, pressure sores and infections.
- Medication – Poly pharmacy, adverse drug reactions and side-effects of drugs.
- Bladder/bowel – Incontinence, retention of urine, urinary tract infection and constipation.
- Locomotion – Gait, movement disorders, arthritis, musculoskeletal disorders and circulation.

All elderly should be assessed regularly for frailty, pain, breathlessness, falls, insomnia and loneliness. Baseline investigations should be carried out to identify the basic functional status of the individual (e.g. fasting blood sugar, lipid profile, renal liver and thyroid function tests, full blood count, ESR and urine full report). All other investigations needed would be decided based on the Current Health Status.

The adoption of a healthier lifestyle even in later life can lead to increased life expectancy with reduced disability and reduced healthcare expenditure.

**Important facts for Active Healthy Ageing**

- ***Avoid smoking and exposure to air pollutants***:
    - Avoid environmental pollution
    - Avoid use of any form of tobacco
    - Be concerned about second-hand smoking
    - Be concerned about occupational air pollution
    - Minimize the use of firewood and try to use LP gas instead
- ***Avoid alcohol and other toxins***:
    - Avoid use of any type of alcohol
    - Avoid chewing betel, areca nut, tobacco and chunam
- ***Carry out physical exercise regularly***:
    - At least 150 minutes of moderate-intensity aerobic physical activity (walking, swimming, balance training exercises and strengthening exercises) throughout the week
    - 75 minutes of vigorous-intensity aerobic physical activity throughout the week
    - The elderly with poor mobility should perform physical activity to enhance balance and prevent falls on 3 or more days each week
    - Disabled elderly should do physical activity as their abilities and conditions allow
    - Breathing exercises are important for healthy lungs
    - Seek advice from a physiotherapist with regard to suitable exercises if there are disabilities
- ***Practice healthy eating habits***:
    - The food pyramid provides a basic structure for the diet
    - As older adults have a greater protein need, protein-rich food is recommended (eggs, lean meat, fish, beans, lentils, peas and milk)
    - Take moderate amounts of carbohydrates, based on weight and physical activity (rice, cereals, string hoppers, hoppers and bread)
    - Take less red meat (beef and pork), cheese, bakery items and deep fried food

  - Reduce salt intake to 5gm per day
  - Add calcium, potassium and vitamin D rich food (small fish and milk)
  - Include plenty of nuts, fresh vegetables, green leaves and fruits in diet
  - Drink adequate water
  - Certain physiological changes may demand a higher nutrient intake. Ensure an increase in the varied diet but not artificial supplements
- Seek medical advice regularly and control high blood pressure, cholesterol and diabetes:
  - Review the list of medications and reduce the number of drugs to a minimum
- ***Take care of vision***:
  - A self-check of vision at home covering one eye at a time, while reading a calendar or small-print by all elderly is recommended
  - Comprehensive routine screening of all elderly to minimize visual impairment due to progressive and irreversible ocular diseases such as glaucoma, diabetic retinopathy and age related macular degeneration
    - Diabetics – Eye screening annually
    - Non-diabetics – Eye screening every three years
- ***Take care of hearing***:
  - Screen for deafness through a whispered voice test or audiometry
  - When communicating with a person with impaired hearing
    - Maintain eye contact
    - Speak slowly, clearly and loudly without shouting
    - There has to be a good source of light and no disturbances at the place of communication
    - Make sure that only one person speaks at a time
  - Using hearing aids is the most common treatment for hearing loss
- ***Avoiding wrong postures***:
  - Avoid wrong postures and overuse of joints in day-to-day work
- ***Arrange living conditions considering safety and convenience***:
  - Remove slippery carpets and use sticky rugs instead
  - Remove loose or non-fitting shoes or slippers

- Avoid wire cords of electrical instruments across the floors of the house
- Avoid pets obstructing the way
- Raise the height of the chair, bed and commode for those who find it difficult to get up from a chair
- Use of a bedside commode at night for those with impaired mobility
- Safety bars and handrails in corridors, washroom and toilet
- Shower chair in the washroom
- Walking aids whenever necessary
- Ramps and handrails along staircases
- Obtain further advice from an occupational therapist

- ***Practice basic hygienic habits***:
  - Keep nails cut and wash hands frequently with soap and water
  - Brush teeth at least twice daily
  - Maintain good oral hygiene and see the dentist at least once in 6 months
  - Practice cough etiquette
- **Having adequate good sleep**
  - Need to have a good sleep for 7 – 8 hours per day
- ***Stay active***:
  - Keep the mind active. Word puzzles, memory games and reading are good to keep the mind active
  - Be socially engaged and avoid social isolation
- ***Be aware of available social support***
  - Seek medical advice early for infections and other danger signals
- ***Specific advice***:

  **Cancers** – All women should practice self-examination of breast for cancers. Vulnerable women should undergo a pap smear for cervical cancers

  **Respiratory** – Frail elderly with respiratory tract disorders should prevent respiratory tract infections. They could get themselves vaccinated against influenza and also pneumonia

# Media Conference

A media conference was held on the 25th of September to mark the International day for the older people. An introduction to Multidisciplinary team care was discussed and it was attended by a team from the Sri Lankan Association of Geriatric Medicine headed by the President Dr. Padma Gunaratne.


# Forthcoming Events

- **The Annual Academic Sessions of the SLAGM will be held from 30th November to 1st December at the Galle Face Hotel.**
- **A pre Congress workshop will be held on the 29th of November.**
- **"Holistic Care for Elderly" a training Programme for doctors, nurses and allied health professionals will be held in Jaffna on 22nd March**

## New Members

**Sri Lankan Association of Geriatric Medicine is a Non- Governmental Organization registered at the National Secretariat for Non-Governmental Organizations in Sri Lanka.**

Dr. K Chandragupatha Ranasinghe
Dr. J M P MadhavaniJayamaha
Dr. ChampikaAmarasinghe
Dr. P Thushari Gamage


Sri Lankan Association of Geriatric Medicine is now a Non-Governmental Organization registered at the National Secretariat for Non-Governmental Organizations in Sri Lanka, No 90/2, Parakum Mawatha, Battaramulla. The council of the SLAGM wishes to inform all members that, in the process of obtaining registration, the name of the association was changed to Sri Lankan Association of Geriatric Medicine.