SLAGM NEWS

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Message from the President

I wish to express my heartfelt gratitude to the past presidents and members of SLAGM for placing their trust in me and electing me as the President for the year 2023/2024. Being chosen for this prestigious position as the 5th President is a great honor, especially when following in the footsteps of
4 illustrious past presidents.

SLAGM, with its vision of "To ensure active and healthy ageing in Sri Lanka," was founded on 19th February 2014. As one of the founding members, I take immense pride in having served on the first council of SLAGM, working towards accomplishing its mission and advancing our goals in Geriatric healthcare. This year marks the special occasion of celebrating the 10th anniversary, making this role even more meaningful and significant.

Among the nations in South East Asia, Sri Lanka is undergoing the most rapid ageing of its population. As individuals grow older, their healthcare needs naturally increase, posing challenges in accessing suitable medical services. Thus, there is a pressing need to educate and train healthcare providers who can adeptly cater to the distinct requirements of older individuals and serve the community with comprehensive knowledge, appropriate skills, and positive attitudes.

Over the past 9 years, through our dedicated efforts, comprehensive training programs have been conducted for doctors, nurses, and allied health professionals. Our primary focus has been to raise the standards of care for older patients, both within healthcare institutions and the community.

In the upcoming year, we have an array of academic programs, capacity building activities, and advocacy meetings lined up to enhance the landscape of Geriatric Healthcare in Sri Lanka to unprecedented heights. The Annual Academic session, the pinnacle of our calendar, is scheduled for 27th-29th June 2024 in Colombo. I warmly invite local and foreign delegates to participate in this event.

I extend my heartfelt gratitude to all the council members who have volunteered to be part of the SLAGM family for 2024. We are determined to pursue our goals and make a positive impact on Geriatric Healthcare in Sri Lanka. Together, we will strive to enhance the quality of life for our older citizens and ensure their well-being in the years to come.

Dr Barana Millawithana
President,
Sri Lankan Association of Geriatric Medicine

Message from the Editor

Dear All,

Greetings and warm wishes to all of you, as we find ourselves in the midst of another enlightening year dedicated to the noble field of geriatric medicine.
It is a great pleasure to be connected to all of you though our bi – monthly newsletter "SLAGM NEWS" once again! As we commence the new academic year of SLAGM, following the Annual General Meeting that was held on 28th of July 2023 the new Council with the newly elected President Dr.Barana Millawithana looks forward to a fruitful year with all its members and those of you who are willing to collaborate with us in this journey towards making the lives of older people happier, healthier and more meaningful.

Our theme for this year is "Enhancing the landscape of Geriatric Medicine." The year ahead has been well planned with many academic activities, training forums, regional meetings, annual academic session, research activities and public education workshops and many more. Our newsletter will showcase all the ongoing activities of SLAGM and, further will be a platform to publish articles related to geriatric medicine and elder care. At this moment I wish to invite all of you to collaborate with us, to provide valuable insights, knowledge, and resources to our community. Your expertise and experiences are invaluable in shaping the discourse around geriatric medicine and enhancing the care we provide to our elderly population.

We believe that your unique perspectives and contributions can greatly enrich the content of our publication. Whether you have groundbreaking research findings, case studies, clinical insights, or personal stories to share, we eagerly welcome your submissions.

Why Should You Contribute?
Your articles will reach a diverse audience of healthcare professionals, researchers, caregivers, and policymakers who are passionate about geriatric medicine. By sharing your expertise, you can influence the field and inspire positive change.
Furthermore, contributing to the newsletter provides an opportunity to connect with fellow experts, fostering collaborations and discussions that can drive innovative solutions in elderly care.

Your contributions will be acknowledged in the newsletter, showcasing your commitment to advancing the field of geriatric medicine and your dedication to the betterment of elderly lives.

How to Contribute:
Choose a Topic: Select a topic that aligns with your expertise and addresses current trends, challenges, or innovations in geriatric medicine.
Write with Purpose: Craft an engaging article that educates, informs, and sparks meaningful conversations. Whether it's a research paper, a case study, or a personal reflection, ensure your content is relevant and impactful.

Submission Process: Email your article to (SLAGM newsletter@email.com] by 15th of each month. Please ensure that your article follows the formatting guidelines provided in the attached contributor's guide.
Review and Publication: Our editorial team will review your submission and work with you to finalize the content if necessary. Once accepted, your article will be featured in an upcoming issue of our newsletter.
Your insights have the power to shape the future of geriatric medicine, fostering a community of compassionate and knowledgeable professionals dedicated to providing the best care for our elderly population. We look forward to reading your contributions and continuing our collective journey towards enhancing the landscape of geriatric medicine in Sri Lanka!.

Thank you for your ongoing support and dedication.

Warm regards,

Dr.Achala Balasuriya
Editor-in Chief
Sri Lankan Association of Geriatric Medicine Newsletter
Wijerama House
Colombo

ANNUAL GENERAL MEETING OF SLAGM, 2023

The 10th annual general meeting of Sri Lankan Association of Geriatric Medicine was held on 28th July 2023, from 12.30pm to 2pm at the auditorium of Postgraduate Institute of Medicine, Rodney place, Colombo.
Minutes of the 2022 AGM was presented by the secretary Dr. Hiranthini De Silva. It was proposed as true and correct by Dr Padama Gunaratna and seconded by Dr. Lasantha Ganewatte. Prof Kamani Wanigasuriya, the president of SLAGM welcomed the members to the tenth AGM of SLAGM. She thanked the membership and the council for the support they have given to successfully carry out the activities. Dr. Hiranthini De Silva presented the secretary's report in which she elaborated on the activities of the SLAGM as the apex body of the Geriatric Medicine in Sri Lanka. Dr Shehan Silva presented the treasurers report.

The resolution on changes to the membership fees was accepted by the membership without any objections.
Dr. Barana Millawithana thanked the membership for supporting his appointment as the president. Being one of the founder members and serving on the first council and being part of 8 councils he reminisced the history of SLAGM, and the milestones achieved thus far. He highlighted that Geriatric Medicine addresses the clinical, preventive, remedial, and social aspects of aging, while emphasizing the insufficiency of a solely organ-based or disease-centered approach in elderly care, therefore a holistic approach involving various healthcare professionals, ranging from primary care physicians to specialists, is essential to achieve excellence in Geriatric Healthcare.

He pledged to lead the association in its continued pursuit of excellence and growth in Geriatric Medicine.
Dr Millawithana further gave a brief overview of the activities for 2023/24 which will include the Academic sessions, academic programme in periphery, monthly clinical meetings, trainee's forum for ppostgraduate trainees and community work.
Then the new council for the year 23/24 was appointed with the following members.

Name	Designation
Dr Barana Millawithana	President
Dr. Manilka Sumanatilleke	Vice president
Dr Kapila Ranasinghe	Vice president
Dr Lasantha Ganewatta	President Elect
Dr Hiranthini de Silva	Joint secretary
Dr Malsha Gunathilaka	Joint secretary
Dr Indika Kulasinghe	Treasurer
Dr. Vajira Dissanayake	Assistant treasurer
Dr.Achala Balasuriya	Editor
Prof Kamani Wanigasuriya	Immediate Past President
Dr Shehan Sillva	Immediate Past Treasurer
Dr. Anushika Abeynayaka	Immediate Past Secretary
Dr. Nipuni Ibulgoda	Council member
Dr Yasas Abeywickrema	Council member
Dr. Dumita Govindapala	Council member
Dr Narmada Goonethilaka	Council member
Dr Kishara Gooneratne	Council member
Dr. Namal Weerakoon	Council member
Mrs. Asha Wettasinghe	Council member
Dr Shiromi Maduwage	Council member
Dr Dilusha Lamabadusuriya	Council member
Dr. Chathura Angulugaha	Council member
Prof. Shyamale Samaranayaka	Council member
Dr. Marylou Dharmakan	Council member
Dr. Judith Herath	Council member
Dr. Keshab Muttupulle	Council member
Dr. Chamila Dalpadadu	Council member
Dr. Warsha De Zoysa	Council member
Mrs. Chandrani Herath	Council member
Dr. Udayangani Ramadasa	Council member
Dr. Amodha Medagedara	Council member
Dr Anuprabha Wickramasinghe	Council Member
Dr Padma S. Gunaratne	Past President
Prof. Sarath Lekamwasam	Past President

SLAGM ANNUAL GENERAL MEETING 2023 HIGHLIGHTS

TRAINING AND EDUCATIONAL ACTIVITIES

AGEING AND SEXUALITY

Dr.Prageeth Premadasa
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Fellow of European Committee of Sexual Medicine
Consultant Venereologist
Provincial Hospital, Polonnaruwa

The term sexuality has many definitions. A simple definition is "the state of being sexual or sexually active (1). Male erectile dysfunction (ED) and female sexual dysfunction increase with age. About a third of the elderly population has at least one complaint with their sexual function. However, about 60% of the elderly population expresses their interest for maintaining sexual activity. Although aging and functional decline may affect sexual function, when sexual dysfunction is diagnosed, physicians should rule out disease or side effects of medications. Common disorders related to sexual dysfunction include cardiovascular disease, diabetes, lower urinary tract symptoms and depression. Early control of cardiovascular risk factors may improve endothelial function and reduce the occurrence of ED. Arteriogenic ED is associated with incident major coronary events independent of conventional cardiovascular risk factors. Treating those disorders or modifying lifestyle-related risk factors (eg obesity) may help prevent sexual dysfunction in the elderly. Not surprisingly, a number of psychological factors that influence the sexuality of younger persons also affect older men and women. Of particular importance is the nature of the interpersonal relationship. Marital conflict, relationship imbalances, commitment issues, intimacy and communication problems, lack of trust, mismatches in sexual desire, boredom, and poor sexual technique are just some of the common sources of sexual dissatisfaction noted among couples of all ages. There are few common sexual dysfunctions found in elderly population.

Male sexual dysfunctions in elderly

The typical male sexual response cycle which is comprised of excitation, plateau and orgasm phases is usually modified with aging as the plateau phase is prolonged and the duration of orgasm is reduced due to decreased expulsive ejaculatory force. Furthermore their refractory period is also increased significantly which leads to a reduction of the frequency of sexual intercourse . Corpora carvernosa elasticity and penile sensitivity reduced in a significant manner. Achieving and maintaining an erection more dependent on direct physical stimulation. Partners may facilitate the erectile response by providing a more intense stimulation 2, However it's been found that with advancing age normal erections are not an absolute prerequisite and coital intercourse is not an absolute prerequisite for women to remain sexually active 3 . Medical or surgical therapy for a number of age related diseases can affect erectile function by interfering with the neurologic innervation of the penis. Interventions that may have this effect include lower abdominal surgery, pelvic irradiation, and certain types of prostate surgery. However sexual dysfunctions like premature ejaculation declines as a function of aging and when it occurs it is commonly associated with prostatitis4.

The age-related decrease in libido noted among men is most frequently attributed to a decline in testosterone levels and to changes in receptor site sensitivity to androgen. The sex hormone status of a healthy man remains relatively stable from puberty until the fifth decade of life, at which time androgen production gradually declines. The first sign of an alteration in endocrine function is a small increase in pituitary-stimulating hormone levels (gonadotropins), which signals the relative inability of the aging testes to efficiently produce testosterone. Serum testosterone levels gradually decline as a consequence, and by age 80 they may be only a sixth those of a younger man.6 Although the drop in serum testosterone levels clearly parallels the decline in sexual libido noted with age, there is little evidence to suggest that testosterone replacement therapy augments sexual drive in men with normal baseline testosterone levels.

Female sexual dysfunctions in elderly

Similar to the men females also encounter sexual dysfunctions more frequently when they age. Reduced and delayed vaginal Vaso congestion can often lead to reduced lubrication, dryness and

painful intercourse . Women also show an increase in the plateau phase and the length of the refractory period as far as their sexual response cycle is concerned. The orgasmic response also become weaken due to poor pelvic floor contractions. Menopause, which occurs in most women at about age 50, is associated with substantial reductions in estrogen, progesterone, and androgen levels. Following menopause, estrogen is almost exclusively derived from the peripheral conversion of adrenal androgens. Around age 65, there is a further decrease in adrenal androgen production, often referred to as adrenopause. Reduction of estradiol but no modification of testosterone in physiological menopause leads to sexual dysfunction in menopaused women and lack of estradiol determines an increased prevalence of vagina dryness. However the effect of hormone replacement therapy on sexual function in menopausal women is modest 5. Topical estrogen therapy improves sexual function in postmenopausal women with vulvovaginal atrophy and is considered first-line treatment of vulvovaginal atrophy.

Sexuality is important for older adults, but interest in discussing aspects of sexual life is variable. Physicians should give their patient's opportunity to voice their concerns with sexual function and offer them alternatives for evaluation and treatment because staying sexually active in old age has many health benefits including good cardiovascular health and mental wellbeing.

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NEUROLGY QUIZ

Dr.Kishara Goonaratne
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This 69-year-old man comes to the clinic with recurrent falls. He says he often falls backwards. He has features of bradykinesia and rigidity which is symmetrical.

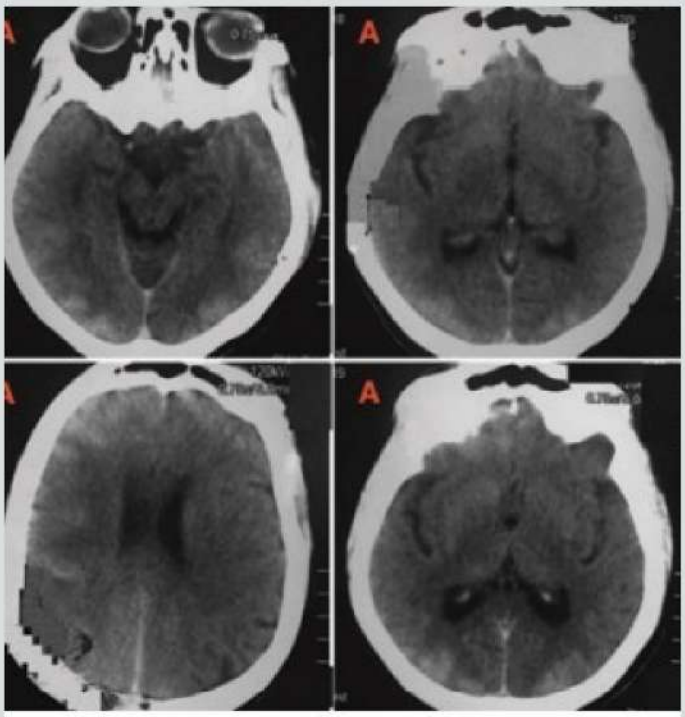
1. Name the physical sign.
2. Specify the diagnosis.

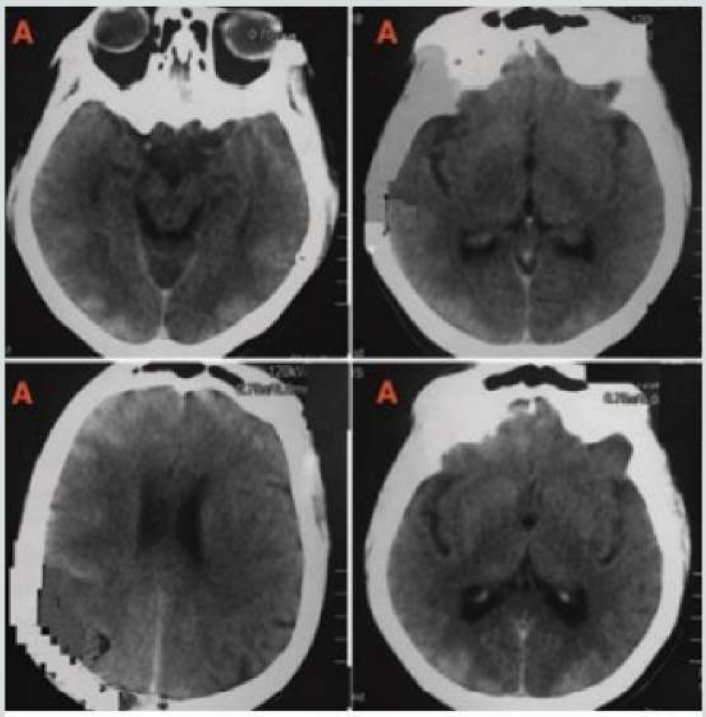
Answer

1. Procerus sign
2. Progressive supranuclear palsy

The Procerus sign is a facial dystonia. It is seen most characteristically in progressive supranuclear palsy. There is contraction of the forehead muscles, particularly the procerus and corrugator, with knitting of the brows, raised eyebrows, lid retraction, widening of the palpebral fissures and reduced blinking. The expression is one of surprise.

A 76-year-old woman with hypertension developed a hemiparesis with confusion and disorientation 3 hours after routine coronary angiography. The procedure had been prolonged, and during it she had received 130 mL of iopromide contrast. A metabolic screen was negative, and cerebral angiography and MR scan of brain were normal. She recovered completely by day 5. The CT brain scans are shown below:





CT brain done immediately after the neurological deficit CT brain done 48 hours later
What is the diagnosis?

Answer

Contrast-induced encephalopathy
Contrast-induced encephalopathy is a rare complication of procedures that require administration of large amounts of contrast, such as coronary angiography. Its clinical features can mimic stroke although it often resolves within 48–72 hours. Hypertension predisposes to the evolution of contrast induced encephalopathy. Investigations to exclude acute stroke following such procedures should avoid additional intravenous or intra-arterial contrast1.
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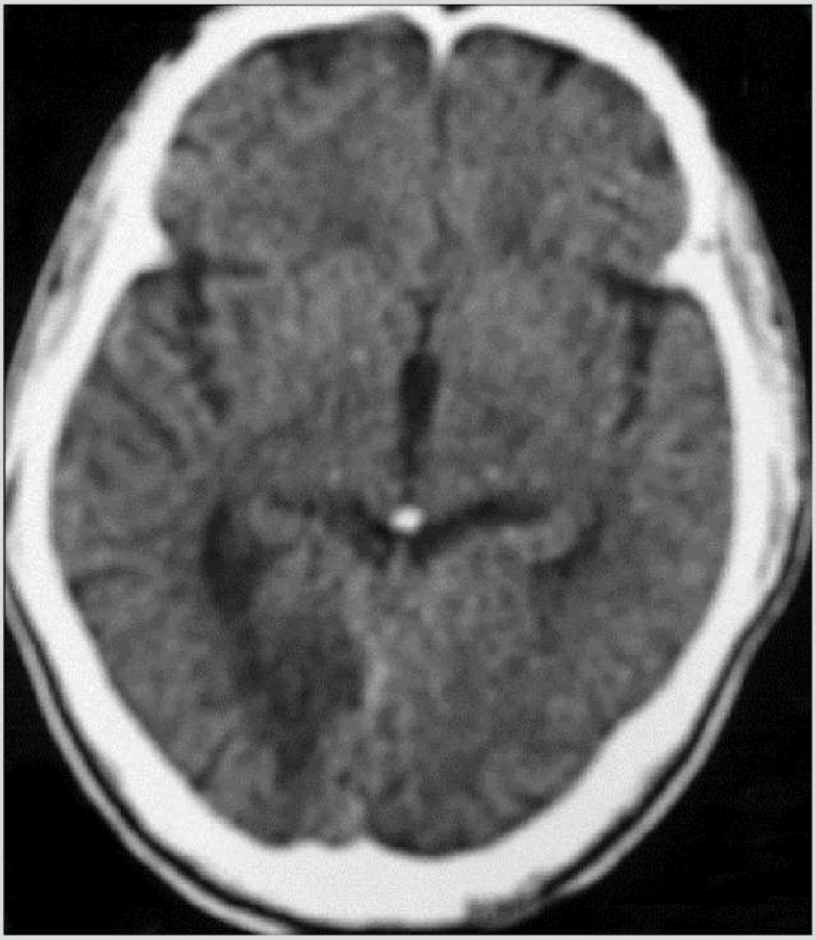
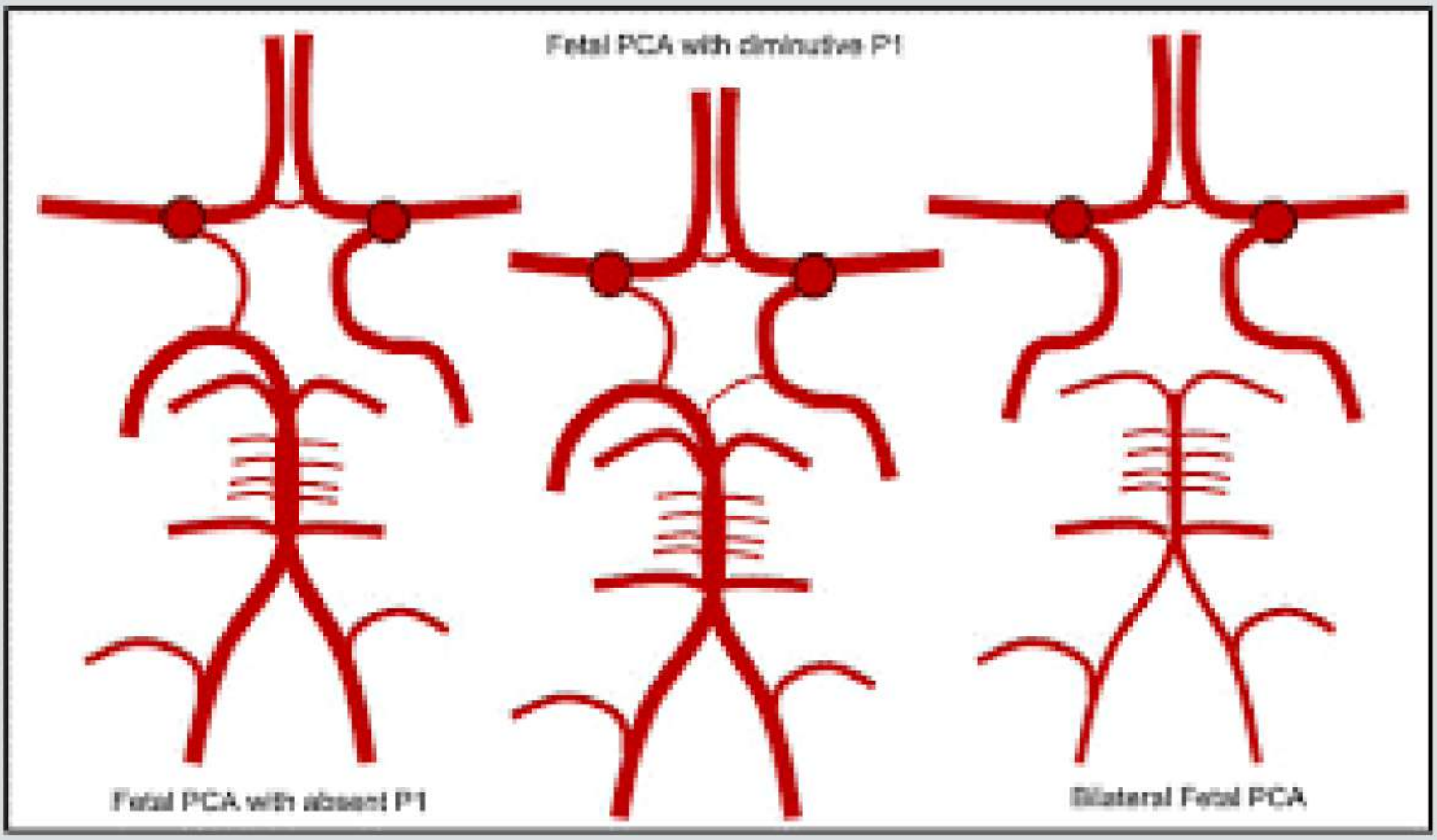


This 72-year-old man presents with left hemianopsia. His CT brain is shown below:

The carotid doppler demonstrated >80% occlusion of the right carotid artery.
Name the artery responsible for the above presentation.
Answer
Persistent fetal Posterior Cerebral Artery (PCA)
A persistent fetal PCA, which takes direct origin from the internal carotid artery, acts as a conduit for embolism from the anterior circulation. Fetal PCA arising predominantly from the Internal Carotid Artery is seen in 4.4% of the Sri Lankan population1.



Shown below is an MRI brain of a 66-year-old woman who was ataxic.

1. Name the radiological sign.
2. State the diagnosis.

Answer

1. Hot cross bun sign
2. Multi-system atrophy type C

The hot cross bun sign is the result of the degeneration of pontine neurons and transverse pontocerebellar fibres. The hot cross bun sign is typically seen in multi system atrophy but not pathognomic for MSA.

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Hypnotherapy in Older Adult

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From awe to skepticism to absolute belief, existing from before the times of the Egyptian Sleep Temples 4000 years ago, Hypnosis has intrigued human beings for centuries. James Braid, a 19th Century British surgeon introduced a physiological dimension to Hypnosis stating that it is a kind of nervous sleep, induced by fatigue resulting from the intense concentration. Braid introduced the term "hypnosis" derived from the Greek God of sleep, Hypnose, in his book Neurypnology (1843). The British and American Medical Associations in 1952 and 1955 respectively, acknowledged Hypnosis as a valuable tool in medicine. The NICE guidelines mention hypnosis as part of the management recommended for IBS and PTSD. Despite these recognitions Hypnosis is still viewed controversially by many in the medical faculty. The value of Hypnosis as a therapeutic modality is perhaps eroded due to stage hypnotists who use hypnosis for entertainment and the dark depiction of it by movies with sinister outcomes on the patients.

How Does It Work?

Hypnotherapy is therapy delivered via Hypnosis by a Hypnotherapist.
Hypnosis works on the basis of the Power of Suggestions. The patient is asked to focus on suggestions of relaxation and calmness which are repeated. This induces a trance state which brings about a narrowed focus of attention and heightened concentration enhancing the person's ability to respond to suggestions. It is during this trance state that a hypnotherapist delivers therapeutic suggestions to the unconscious mind, the reservoir of our memories, experiences and habits.
The trance state induced during therapy is similar to the state of altered consciousness that one experiences when one is totally focused in a book or a movie. The trance state which can vary from light to deep, is characterised by a tremendously pleasant state of relaxation.

The Science Behind Hypnosis

Studies have been conducted to show how the brain waves change with various stages of trance. There are also studies with fMRI which have shown neural changes which are associated with hypnosis. These changes in neural activity underlie the focused attention, enhanced somatic and emotional control, and lack of self-consciousness that characterizes hypnosis.

Myths and Facts about Hypnotherapy

A person cannot be hypnotized against their will, contrary to what the malevolent movies portray. In or out of trance, we only accept suggestions which make sense to us. Just like any clinical sessions, the therapeutic relationship between the patient and therapist is important. For hypnotherapy to work, a patient must trust, have rapport and collaborate with the therapist. Detailed clinical history must be taken. The suggestions delivered must make sense to the patient. A lot of work is put into creating the script as it must resonate with the patient.
Tailor made therapy with suggestions specifically to help patients work on their issues is delivered to patients by a trained hypnotherapist in a structured manner. At the end of the therapy session, the hypnotherapist wakes the patient up. Those who practice self hypnosis have the choice of either coming out of trance or go into deep refreshing sleep when practiced at night.
Therapy is done for the specific purpose of healing, breaking a habit, maximising potential, changing limiting beliefs and behaviours, gaining insight and also help some come to terms with their past and move on with live. Therapy can be stand alone or in combination with other medical disciplines for example Psychiatry, Dental, Medical, Orthopaedic, Obstetrics and the Pain Clinic. Hypnosis has also been used successfully in pain management , to enhance performance and for weight loss.

Hypnosis is utilized for a variety of conditions in patients of different age groups. It has also been found to be a valuable add on therapy for the older adult.

Hypnotherapy in the Golden Age

Aging is a natural process. We start aging from the time we are born.
The number of people over the age of 65 is increasing at an accelerated rate especially in developing countries. Living in a community has been replaced by living in condominiums and gated housing areas where neighbors nowadays do not know each other. Despite the advances in science, technology and multimedia, the world is becoming a lonelier place. Many older adults are left to fend for themselves. Proper medical facilities and infrastructures should be in place to help older adults enter the final phase of lives with dignity.

Instead they face the prejudice of ageism labeled with decrepitude which further adds on to their own set of physical and mental health challenges and concerns.

In their old age when they are alone or less occupied that they used to be, with nothing but time on their hands, many older adults sit and ruminate about their past, their regrets, the wrong
choices made. Those who had worked before, may go through a period of adjustment post-retirement. They feel they have lost their relevance, usefulness and independence. The rate of anxiety is quite high among this group. Many older adults are burdened with aches and pain which restrict their movements and deprive them of participating in social activities. The very thought of aging can be daunting for some who view this natural process with fear and anxiety. Some sink into depression and isolate themselves. The rate of suicide is also high among the older adults. Sleep deprivation is another concern that affects the older age group. Practicing self hypnosis at night allows them to go into peaceful slumber and wake up feeling refreshed.

Older adults must be educated that aging naturally doesn't need to be a bleak and hopeless process. With so much time for themselves finally, they need to be encouraged to do something for themselves instead of dreading the lonely long silent years. At the same time, the mind set of the community towards age bias must be changed as well. Aging healthily is possible and it is the right of every older adult. To age healthily, one needs to be free from stress, maintain a healthy life style, have proper medical care, socialize and have a healthy mindset.

Chronic pain, loneliness, physical ailments, financial challenges are often the woes that eventually lead many older adults to become desolate. The use of hypnosis can be used to enhance general wellbeing and to alleviate chronic pain, a common problem for those in this age bracket. By practicing self-hypnosis older adults can give themselves suggestions of motivation , calmness while visualizing themselves being healthy.

Age Healthily with Hypnotherapy

Stress is destructive and hastens aging. It can trigger new physical or mental health disorders or worsens existing ones. Being alone, facing illness, being uncertain about their future, fear of death are some of the reasons many older adults become anxious about.
Relaxation on the other hands helps the body heal and recuperate. Hypnosis triggers the relaxation response within us. By practicing self-hypnosis, giving themselves suggestions of staying healthy and visualizing themselves being healthy, older adults can prevent themselves from experiencing the unnecessary damaging effects of stress. As hypnosis brings about relaxation, by practicing this regularly, the feeling of anxiety can eventually be replaced by calmness.

Pain is a warning sign that something is not right in the body. It would be unethical to remove pain altogether. The cause of pain is usually multifactorial in older adults. It can be due to stress, arthritis, old physical trauma, the wear and tear of joints. In older adults, it can also present as one of the symptoms of depression. Teaching them self-hypnosis to control their pain will empower them into having some control in their lives and managing their health. The ability to go into deeper trance comes with the regular practice of self-hypnosis. Not only does this help with enhancing an overall wellbeing, it can be an enjoyable experience and a healthy way to pass time.

Some studies have shown beneficial results in people suffering from Dementia. Personally, I have not used hypnosis on patients with Dementia. I have done hypnosis for younger and older adults who have family history of dementia or those who express concerns about fearing memory impairment. They are then taught self-hypnosis to give themselves simple suggestions to strengthen their memory.

Ethical Hypnotherapists do not tell patients to disregard their medical treatment. They instead use hypnosis to help enhance their adherence to medications prescribed, strengthen their will power and motivation and improve their overall wellbeing. This can be applied for the older adults as well.

Hypnotherapy can be beneficial in helping older adults age healthily, enjoy more mobility and lesser pain, renew their motivation and will to live with more hope and look forward to living with dignity. It can never replace their medical treatment but can be used as an adjunct to help improve their quality of life.

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Diabetes Care for Sri Lanka's Elderly: A Holistic Approach

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Senior Registrar in Geriatric Medicine
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Managing diabetes in elderly patients within the healthcare setting of Sri Lanka presents unique challenges that demand a blend of medical expertise and compassionate care. This article explores the complexities of managing diabetes in elderly individuals, focusing on key areas: diagnosing diabetes, self-management strategies, addressing the risk of hypoglycemia, understanding the link between diabetes and depression, and recognizing the association between diabetes and dementia. Additionally, we discuss the use of oral pharmacotherapeutic agents tailored to older people in the country.

Diagnosing Diabetes in the Elderly; Why it is different?
Diagnosing diabetes in elderly patients is intricate due to age-related factors obscuring traditional diagnostic markers. Glucosuria may not manifest as expected due to increased renal glucosuria thresholds with age. Polydipsia, a classic diabetes symptom, may not be apparent due to altered thirst perception in the elderly. While diagnostic criteria for diabetes remain the same, interpreting HbA1c values in the elderly requires caution due to modifiers that can artificially elevate or depress its value, such as anemias and bleeding disorders. Recognizing these nuances is crucial for effective diabetes management.

Self-Management of Diabetes for the Elderly
Effective diabetes management demands proactive patient involvement, including healthy eating habits, regular physical activity, vigilant blood sugar monitoring, strict medication adherence, proficient problem-solving, coping strategies, and risk reduction. Elderly patients face unique challenges due to prevalent comorbidities. Self-regulation is essential for type 2 diabetes patients to maintain normal glucose levels. Understanding age-related factors, like impaired vision, hearing, joint diseases, cognitive decline, and emotional challenges, is vital for effective self-care.

Risk of Hypoglycaemia

Elderly patients face challenges regarding the risk of hypoglycemia, often necessitating nuanced management. Notably, asymptomatic hypoglycemia is common in the elderly due to the absence of adrenergic alarm symptoms. Adjusting hypoglycemic treatment to align with renal function is crucial to prevent adverse outcomes.

Hypoglycemic events can lead to falls, fractures, cognitive decline, hospitalization, cardiovascular events, and mortality. Identifying risk factors, such as insulin use, chronic kidney disease, cognitive impairment, frailty, and polypharmacy, is essential for managing hypoglycemia effectively

Depression and Diabetes

Type 2 diabetes patients have a higher rate of depression compared to the general population, with a concerning mortality rate. Depression can accelerate microvascular complications linked to diabetes. The American Diabetes Association recommends annual screening for depressive symptoms in all diabetes patients at the time of diagnosis and annually thereafter. Addressing this bidirectional relationship between depression and diabetes can enhance overall well-being.

Diabetes and Dementia

Type 2 Diabetes Mellitus (T2DM) is closely linked to a 50% increased risk of dementia, marked by global brain atrophy and small-vessel disease. Cognitive decline often begins during prediabetes. Risk factors for cognitive decline in elderly diabetes patients include poor glycemic control, hypoglycemic and hyperglycemic events, comorbid depression, and vascular complications. A history of severe hypoglycemia increases the risk of dementia and vice versa. Screening adults aged 65 and older for cognitive impairment or dementia is now recommended, even if challenging due to time constraints in healthcare settings. Screening tools such as mini-cog, MMSE and MoCA can identify cognitive impairment requiring further evaluation.

Treatment Goals in Frail Elderly Patients

Frailty in older adults often reduces insulin resistance, necessitating smaller insulin doses for adequate glycemic control. Some frail elderly individuals have low HbA1c levels, raising questions about the need for anti-hyperglycemic therapies.

Modifying treatment regimens requires caution, as even removing a low-dose component can lead to rebound hyperglycemia.

The potential risks of intensive glycemic control may outweigh benefits in cases of very long-standing diabetes, severe hypoglycemia history, advanced atherosclerosis, and advanced age and frailty.

Achieving a balance between avoiding hypoglycemia and hyperglycemia is crucial, considering life expectancy and individual circumstances.

End of life considerations

For type 2 diabetes patients approaching the end of life, discontinuing all medications may be reasonable when oral intake is unlikely. Clear communication with patients and their families is essential to avoid misconceptions about treatment de-escalation. Emphasizing improved symptom management, overall function, and quality of life is key, ensuring patients' comfort and well-being during this phase.

Oral Diabetes Medications for Elderly Patients in Sri Lanka

Metformin

Cost-effective with cardiovascular benefits but may cause gastrointestinal side effects and weight loss. Contraindicated in advanced chronic kidney disease. And has a potential leading to vitamin B12 deficiency on long use.

Sulphonylureas (e.g., gliclazide, glimepiride)

Inexpensive and effective but has a significant risk of hypoglycemia, increasing with age-related weight loss and prevalent chronic kidney disease. Glibenclamide (glyburide) should be avoided in the elderly due to safety concerns.

DPP4 Inhibitors (e.g., Sitagliptin, Linagliptin)

Well-tolerated with low hypoglycemia risk, suitable for elderly patients with irregular eating habits. Dosing adjustments are necessary in renal failure, except for linagliptin. Their glucose-lowering efficacy is mild, and they have neutral cardiovascular benefits.

SGLT2 Inhibitors (e.g., Empagliflozin, Dapagliflozin)

Exciting newer drugs with proven cardiac, renal, and metabolic benefits but come with urogenital infection risks and potential volume depletion. Orthostatic symptoms may occur due to their diuretic effect, with euglycemic ketoacidosis a concern during concomitant illness. Avoid in acute illnesses requiring hospital admissions and in catheterized bed bound patients.

Selecting the right oral pharmacotherapy for elderly diabetic patients in Sri Lanka requires careful consideration of individual needs and risks. Each medication class has advantages and drawbacks, and treatment should be tailored to the patient's specific circumstances.

In navigating the intricate landscape of diabetes management for the elderly in Sri Lanka, healthcare professionals find themselves at the intersection of medical expertise and compassionate care. Recognizing the unique challenges posed by age-related factors and comorbidities empowers healthcare providers to help elderly patients lead healthier lives. Balancing optimal glycemic control with the preservation of quality of life through tailored strategies, regular assessment, and vigilant monitoring is key to improving the well-being of elderly diabetic patients, ensuring they enjoy fulfilling and meaningful lives in their golden years.

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Growing Old

Matthew Arnold (1822-88)

What is it to grow old?
Is it to lose the glory of the form,
The lustre of the eye?
Is it for beauty to forgo her wreath?
—Yes, but not this alone.

Is it to feel our strength
Not our bloom only, but our strength—decay?
Is it to feel each limb
Grow stiffer, every function less exact,
Each nerve more loosely strung?
Yes, this, and more; but not
Ah, 'tis not what in youth we dreamed 'twould be!
'Tis not to have our life
Mellowed and softened as with sunset glow,
A golden day's decline

DELIRIUM – A CASE-BASED DISCUSSION

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A 75-year-old diabetic lady presented to the Emergency Room with high grade fever and generalized weakness of a short duration. On further evaluation, she was found to have Dengue Fever. She was hospitalized and later shifted to the Intensive Care Unit (ICU) for closer monitoring owing to her falling platelets, advancing age and hypotension. While her clinical parameters improved over the next two days, a disturbance of her sleep cycle was noticed as she refused to take any medications or food. She was noticed to speak irrelevantly and incoherently at times. Soon she became agitated and aggressive insisting on going home. Neurological exam did not reveal any focal deficit while metabolic parameters were normal. With a provisional diagnosis of delirium, she was given haloperidol, shifted out of the ICU and encouraged to have good sleep hygiene. On day five, in the evening, her symptoms improved and was reported to have had a good overnight sleep. She was later discharged on oral anti-diabetic agents. On subsequent follow-up, she had recovered and was doing well.

Introduction

The case above emphasizes a characteristic presentation of delirium in an older patient. The word 'delirium' originates from the Latin word 'delirare' which implies – being deranged.1 Delirium is a neuropsychiatric syndrome which manifests as a derangement in the cognitive function which can range from unnoticeable deficits in attention to a completely altered sensorium like in a coma state. Patients often present in an acute confusional state with agitation.2 The symptoms in a patient usually keep fluctuating with time and in severity. It causes significant distress to the patient as well as their caretakers.

Delirium is defined with a combination of features as per criteria in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5).4 There has been considerable overlap in defining and diagnosing delirium and encephalopathy. Delirium is a clinical syndrome whereas encephalopathy encompasses an underlying pathobiological process which may manifest as delirium or as coma in severe cases.

Epidemiology

The prevalence of delirium varies in patient groups according to age and hospital settings. It is seen more commonly in older adults. Prevalence is higher in patients undergoing major surgeries as compared to those undergoing minor procedures with good underlying health conditions.5 Data on the prevalence of delirium in community settings is lacking. Among nursing homes, the prevalence is reported to be 4.3-38% depending on the setting and the criteria used for defining the symptom complex around delirium.6 Among ICU patients, the prevalence is as high as 50-70% especially in mechanically ventilated patients.7 Presentation
Delirium can present with an array of symptoms ranging from mild attention deficits to severe derangements in neurological functions and a comatose state. Patients can present with difficulty remembering instructions and may ask a question or talk about a thing repetitively. Memory deficits and forgetfulness may be the initial complaints. Patients with delirium may demonstrate attention

difficulties. They do not remember instructions and may ask that directions and questions be repeated. Disorientation to time and place is frequently observed. Many patients become agitated during hospital stay or severe illness and may express discomfort in a hospital environment. They might often refuse treatment and medications.
Prolonged hospital stay is also associated with a blunted affect, decreased appetite, decreased motivation, and disrupted sleep patterns. Emotional lability, perceptual disturbances and neurological deficits can occur in extreme cases.

Risk Factors

1. Factors related to underlying health condition –
a. Older age
b. Underlying Dementia
c. Presence of multiple comorbidities
d. Substance abuse/alcohol intake
e. Illiteracy
f. Underlying psychiatric illness
2. Factors related to an illness –
a. Surgical intervention
b. Severe and acute illness
c. Electrolyte imbalance
d. Prolonged ventilation
e. Drug withdrawal
f. Illness requiring hospitalization to a critical care setting
3. Other associated factors –
a. Polypharmacy
b. Sedation
c. Sleep deprivation
d. Physical restraints
e. Emotional factors associated with illness and hospital environment

Subtypes

Delirium can be categorized as hyperactive, hypoactive or mixed, according to the level of consciousness and derangement in behavior. 8

1. Hyperactive – Patients are agitated, disoriented and delusional. This presentation is often confused with a psychotic disorder.
2. Hypoactive- Patients are apathetic and in a suppressed level of consciousness. Diagnosis in hypoactive patients is often confused with depression.
3. Mixed – These patients keep wavering between the above two types with time.

Diagnosis

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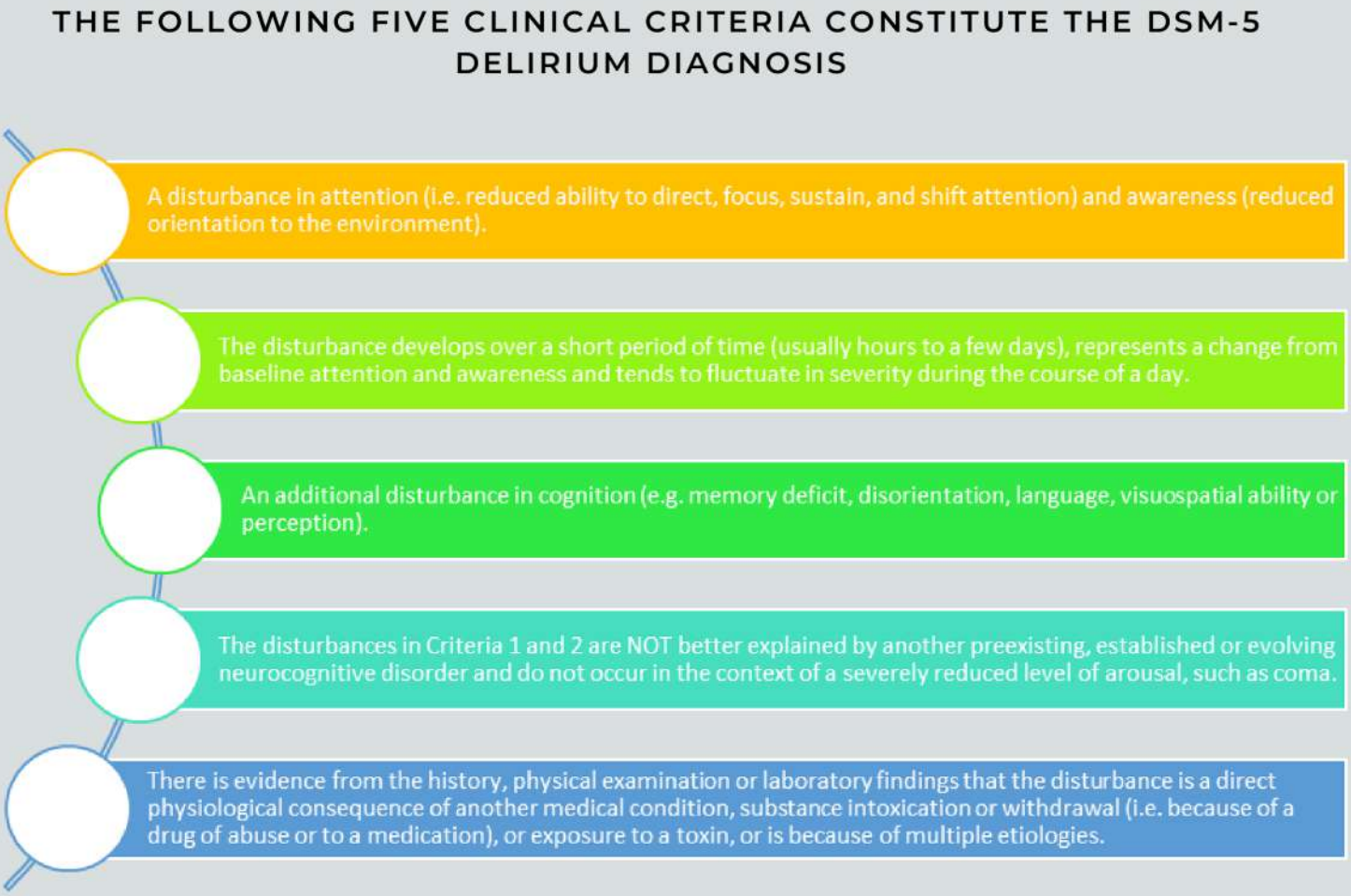


Factors associated with delirium

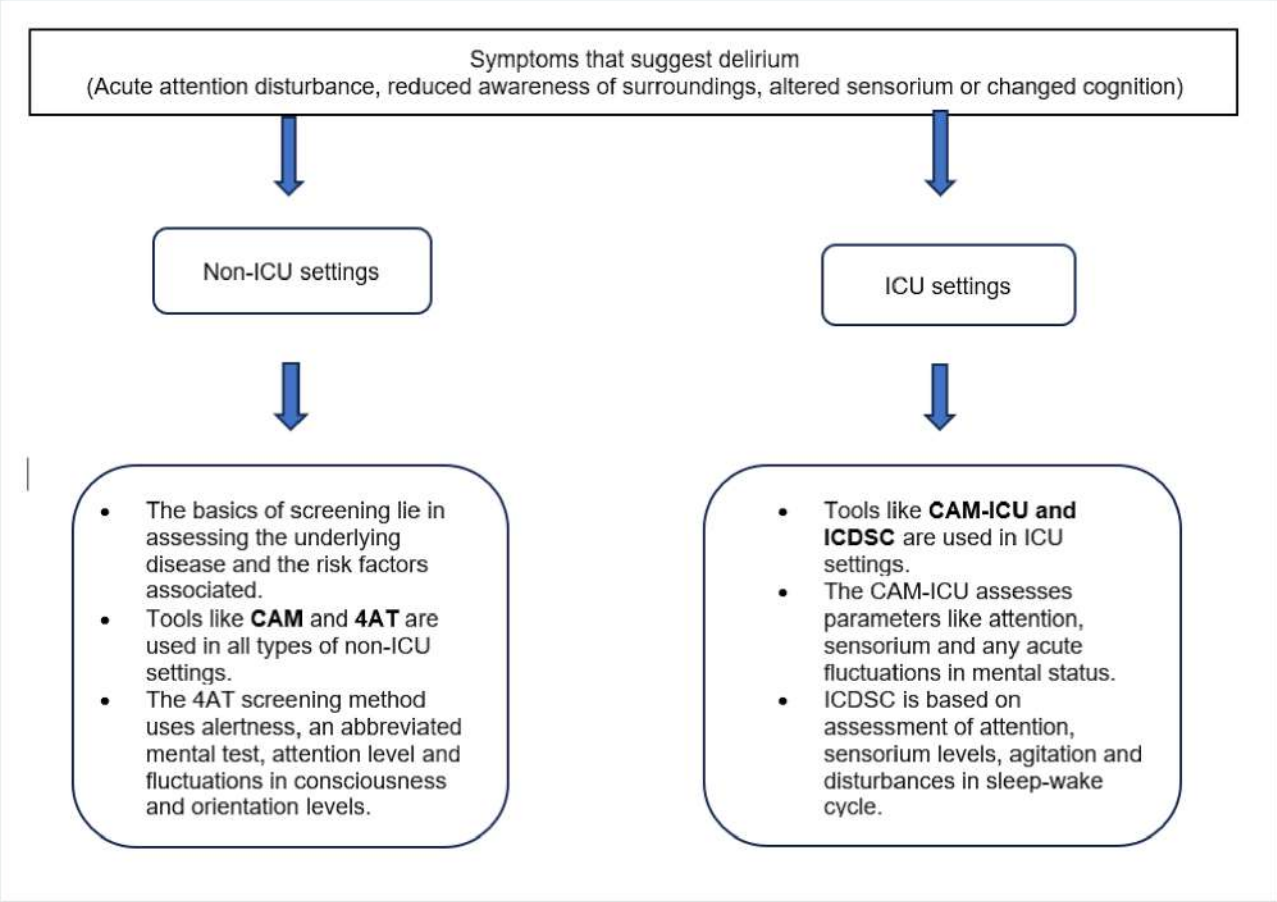
The factors that cause disease manifestations and altered sensorium are responsible for causing Delirium.10 Several mechanisms that have been proposed to be involved in occurrence of delirium.11 While direct brain insult due to hypoxia or infection may lead to underlying brain injury, aberrant stress responses have been reported to cause acute delirium due to contribution of the underlying disease state itself. Older individuals can have unrecognized clinical scenarios that precipitate delirium, such as infections, urinary retention, hydration status, etc.

Older age is a major predisposing factor for delirium. Underlying central neural system disorders predispose to delirium through alterations in sickness duration and stress response. Dysfunction of the stress response and increased inflammatory states are often observed with aging. Aging itself is a factor causing progressive neurodegeneration.12,13 It has been established that underlying dementia and aging related changes interact with acute injuries and stress factors to precipitate delirium.14 Demographic projections over the next two decades suggest that these are likely to increase, hence, increasing the incidence and prevalence of delirium.15,16

Screening tools

Various screening tools have been developed to identify delirium. While several good tools such as the Confusion Assessment Method (CAM), are available, it is believed that clinical judgment is important.17 Validated to be used in the palliative care patient population, CAM has its sensitivity deeply dependent on user training.18 Combined use of the bCAM, a brief modified version of CAM, along with the Delirium Triage Scale (DTS) has a screening sensitivity of 78–84%.19

Figure 1: Screening tools for identifying delirium based on clinical setting



Legend for figure: Abbreviations: ICU- intensive care unit, 4AT- attention tests, CAM- confusion assessment method, ICDSC-intensive care delirium screening checklist.

Management

The basis of treatment of delirium lies in managing the underlying disease which precipitates it either at a home environment or at a hospital setting.

Pharmacological management

While anti-psychotic medications are the mainstay for immediate management of symptoms, there is a lack of clear evidence-based strategy.20 Haloperidol is the most commonly used antipsychotic used to control symptoms in an acute setting.21 It often results in increased somnolence and urinary retention. The use of antipsychotics is more common in ICU and palliative care.

On the basis of the hypothesis that delirium involves neuroinflammatory markers, circadian rhythm dysregulation and melatonin deficiency, several pharmacological therapies other than antipsychotics have been postulated.22,23,24 Sleep disturbance has been studied to be a prodromal symptom for delirium hence linking it to melatonin derangements.25 Randomized Control Trials have shown improvement in delirium with the use of melatonin.26 Dexmedetomidine, an a2 -receptor agonist, is under trial for need of evidence in use as preventive medicine in ICU patients.27

Non-pharmacological management of Delirium

A decrease in risk factors associated with delirium can significantly contribute to the prevention of delirium. Reducing hospital stay, maintaining sleep hygiene and promoting overall health can contribute to the management of delirium. Psychological therapy guided to improve behaviour responses can also aid in management.

Palliative sedation

The use of palliative sedation is an option for treating refractory agitated delirium.28-32 Sedatives like benzodiazepines may be used for palliation.

TAKE HOME MESSAGE

1. The prevalence and incidence of delirium is on the rise owing to increasing longevity, comorbidity, hospitalization and increased stress
2. Delirium is a clinical syndrome that needs to be differentiated from encephalopathy which is a patho-biological process
3. While anti-psychotics are the current mainstay for symptom management, further studies are needed to establish the management protocols for delirium.

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