PSG Medi Pulse

News ■ Medical ■ Surgical ■ General

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Message

குறள் :

கற்க கசடறக் கற்பவை கற்றபின்
நிற்க அதற்குத் தக.

மு. வரதராசன் விளக்கம் :

பிழை இல்லாதவற்றைத் தனது குறைகள் நீங்குமளவுக்குக் கற்றுக்கொள்ள வேண்டும். கற்ற பிறகு அதன்படி நடக்கவேண்டும்.

Medical

COVID IN ELDERLY

Dr. K. Anupama Murthy MD, DM
Professor & HOD , Department of Geriatric Medicine

The corona virus disease-19 (COVID-19) caused by Severe Acute Respiratory Syndrome Corona Virus 2 (SARSCoV-2) occurs in persons of all ages. Initially cases were reported in patients who were exposed to virus in seafood market in Wuhan, Hubei Province, China in December 2019 It has disseminated worldwide affecting more than 200 countries and declared as pandemic by WHO on 11 March 2020 Worldwide, there have been 14million cases of COVID-19 and more than 5 lakh deaths by mid July 2020.

In elderly due to multiple co morbidities and complex health conditions; high case fatality and poor treatment outcomes have been observed. Physiological changes with age leads to decline in intrinsic capacity, manifested as malnutrition, cognitive decline, and depressive symptoms; those conditions should be managed comprehensively. Early detection of inappropriate medication prescriptions is recommended to prevent adverse drug events and drug interactions for those being treated for COVID-19.

Consistently, age 65 and older is an independent risk factor for death, cardiovascular events, and terminal events requiring IMV (invasive mechanical ventilation) and ICU admission In one of the largest case series so far published, of 72,314 cases reported by the Chinese Centre for Disease Control and Prevention, case fatality was 8.0% (312 of 3,918) in patients aged 70–79 years and 14.8% in patients aged ≥80 years .The case fatality rate varies from 2.3 to 14.8% depending on the demographics of the nation or region, age, severity of the disease and co- morbidities

Clinical manifestations

Mild symptoms are seen in 80% of the patients more common amongst younger populations. Severe symptoms with shortness of breath and lung involvement are reported in 14% of the patients, and 5% develop critical illness, more commonly seen in elderly patients. Elderly males with multiple co morbidities such as cardiovascular disease, diabetes mellitus, hypertension, chronic kidney disease, obesity, and chronic lung diseases are associated with the development of severe Covid infection.

The most common symptoms reported by patients with COVID-19 include fever, fatigue, and dry cough. Less common symptoms include headache, anosmia, cough with sputum production, joint pains, chills, nausea, vomiting, and diarrhea Covid infection can present with atypical symptoms in elderly. They may sleep more than usual or stop eating. They may seem unusually apathetic or confused, losing orientation to their surroundings. They may become dizzy and fall. Sometimes, seniors stop speaking or simply collapse. Underlying chronic illnesses can mask or interfere with signs of infection They may present with postural instability, diarhoea, delirium and unexplained hypoxia, tachycardia or tachypnea Most of the times COVID-19 gets detected in many elderly patients admitted for other complaints such as for falls or surgery.

Blood, radiological investigations, diagnostic modalities are similar to those in adults except that comorbidities, drug dosage, pharmacokinetics, have to be regularly monitored .

MANAGEMENT SPECIFIC TO ELDERLY

- Medical management remains same as in adults, close monitoring of vitals for signs of clinical deterioration, with high index of suspicion for development of complications, early physiotherapy and rehabilitation, adequate hydration other supportive measures, advanced care planning, with psychological mental and spiritual support are additional in management in elderly.
- Care for elderly includes not only conventional history taking, but a thorough understanding of the person's life, values, priorities, and preferences for health management. Ensure multidisciplinary collaboration among physicians, nurses, pharmacists, and other health care professionals in the decision-making process to address multimirbidities and functional decline.

Medical

- Currently, evidence for effective treatment for Covid-19 is rapidly evolving. Presently, treatment is supportive. All cases or suspected cases should be isolated until effective treatments or vaccines become available.
- NICE recommend that the Clinical Frailty Scale (CFS)should be used to provide a functional evaluation of people presenting with COVID-19 in those aged 65 years and over without long-term disability such as cerebral palsy, learning disability or autism. They advise that in patients with a CFS between 1 and 4, who would like to be treated intensively, critical care referral would be appropriate Advanced care planning for those living with frailty, including sensitive consideration about the potential benefits of admission to hospital, is recommended. This is particularly relevant to people resident in care homes or with high clinical frailty scores where advanced care plans should be proactively revisited in the light of the current outbreak.
- Guidelines advocate stratifying people by disease severity however in older people, and those with co morbidity, despite presenting with mild symptoms are at higher risk of severe COVID-19 and of unpredictable, rapid, deterioration.
- Comorbidities should be managed as standard, being careful of the non-specific presentation of disease in older patients to avoid attributing presenting symptoms solely to probable COVID-19 infection.
- Early medication review should occur to reduce the risks associated with polypharmacy and adverse reactions in the context of COVID infection .
- Medical management remains same in elderly patients as in adults but with due importance to drug –drug interactions, adequate control of Comorbidities and good supportive care.
- Loneliness and social distancing in elderly leads to depression, dementia and anxiety which need to be managed as well

POST COVID PERIOD

- Older adults are at greater risk of both severe disease and long time impairment.
- Prolonged hypoxia and widespread inflammation can also damage kidney, liver, heart, brain and other organs.
- Prolonged ventilator stay and acute respiratory distress syndrome (ARDS) can leads to fibrosis and scarring, long term breathing problems.
- Prolonged ICU stay make them prone to set of physical, cognitive and mental health problems known as post intensive care syndrome .
- Prolonged ventilator stay may leads to muscle atrophy and weakness so early physiotherapy, rehabilitation is beneficial.
- Delirium due to prolonged hospital stays which can cause memory deficits and cognitive impairment are common. Polypharmacy and use of sedatives, steroids can worsen delirium.
- Surge in mental health problems like anxiety, depression and post – traumatic stress disorder can follow psychological stress of severe disease.
- Risk of thrombosis and clotting disorders is high which increases risk of cerebrovascular stroke and acute coronary syndrome.
- Risk of myocarditis is seen in mild to moderate patients in post covid period.
- Many patients develop postural Hypotension and giddiness in post Covid period.

Guidelines for prevention

Recommendations given to the general public to counteract the rapid spread of the virus are

- Frequent hand washing, avoid touching eyes, nose, and mouth, social distancing (at least 6 ft, preferably > 13 ft), staying at home, and wearing a cloth face covering when going outside.
- Widespread use of face masks and social distancing have a vital role in decreasing the virus pace of spread.
- Telemedicine services should be encouraged by clinicians for residents to reduce direct contact between provider, staff and residents
- The visits of all nonessential visitors including family members should be stopped.
- Every person including all staff from cooks and housekeeping to nurses and administrators entering the facility should be screened for elevated temperature or presence of symptoms.
- In addition, staff should also be asked if they have had any contact with a COVID-19-positive (or suspected) person.
- To avoid group dining, group therapies, and recreational activities involving large groups.

Medical

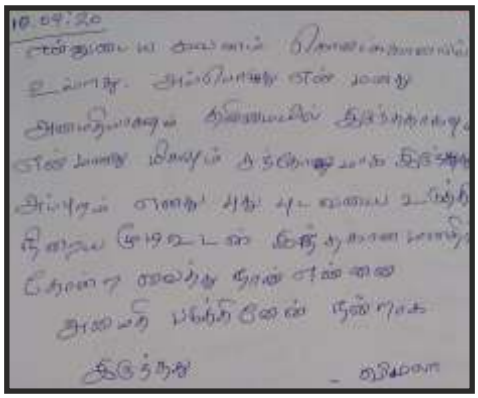
PSG EVENTS

BREAST CANCER DAY

PALLIATIVE CARE DAY

ROSE DAY CELEBRATION

YOGA DAY SECTION



CANCER DAY CELEBRATION FREE YOGA CLASS - YOGA PATIENT FEEDBACK

CANCER DAY CELEBRATION - FREE YOGA CLASS

Medical

HEAL "THY" LIFESTYLE

"Let Food be Thy Medicine and
Medicine be Thy Food" - Hippocrates

Dr. Priya Vasudevan, Department of Preventive Cardiology

The estimated prevalence of Cardiovascular disease (CVD) in India in 2016 was 54.5 million. One in four deaths were due to CVD and in that ischemic heart disease and stroke accounted for almost 80% of it. In India, nearly 5.8 million people (WHO report, 2015) die from NCDs (heart and lung diseases, stroke, cancer and diabetes) every year .In other words, 1 in 4 Indians has a risk of dying from an Non-Communicable disease (NCD) before they reach the age of 70. In a report by Ministry of Health and Family Welfare, Government of India, it was found that there was an increase in the contribution of NCDs from 30% of the 'disability-adjusted life years' (DALYs) in 1990 to 55% in 2016 and also an increase in proportion of deaths due to NCDs (among all deaths) from 37% in 1990 to 61% in 2016. This showed a rapid epidemiological transition with a shift in disease burden to NCDs.

Chronic disease burden has increased in India by 53%. The leading cause of mortality among Indians is Heart disease, that has multiple factors including genetics, environmental causes and more importantly our lifestyle choices like diet, physical activity and stress. All of these factors play a huge role in development of diseases like diabetes, hypertension and obesity, arthritis. WHO has estimated $6.2 trillion has been spent between 2010 and 2030 on health care expenditure for NCDs. The only way to combat this is to focus on prevention and treatment of the root cause of all these diseases, which are unhealthy lifestyle choices.

When we look at these numbers, it is alarming and we all need to understand that there has to be a paradigm shift in the healthcare model. Medical technology has grown, and is growing at an exponential rate focusing on Artificial Intelligence, 3D printing of organs, robotic surgery, gene modification to cut out the threat of the disease etc. It is of course a proud moment for all us to be in this time. But in spite of so much advancement in medicine and technology, where are we as humans? Right now, our average life expectancy is at its highest and we have the most sophisticated things that are known to mankind. But does that mean we are happier and healthier? Actual studies show otherwise. People are constantly living with chronic disease and disabilities. In other words, "we are dying longer".

We have focused all our energy on treating the symptoms of the disease. However, we have become complacent in finding and treating the cause of the disease, which is simply staring at our faces. Yes, think about it for a moment; 80% of our disease is caused by our lifestyle choices. It is the simple truth. Heart disease is the number one killer in the entire world, and it was predicted that in 2020 India will have the most heart disease burden in the entire world. Smoking, Hypertension, diabetes, obesity and dyslipidemia are still the major causes of heart disease. And it affects younger Indians more than their counterparts in the western countries.

Preventive Cardiology is a sub-specialty that focuses on preventing and treating the patients' risks for developing heart disease by using lifestyle interventions. So when we look at some of the statistics given, we can clearly understand why Preventive Cardiology/Lifestyle Medicine is the need of the hour. Here, we focus on Therapeutic Lifestyle Changes (TLC could be taken for "tender loving care" for our wellbeing too), that are a fundamental part of the healthcare system. Importance should be given to 6 domains of lifestyle medicine which are diet, physical activity, stress management, avoiding risky substance use and meaningful relationships. But how much knowledge do we have regarding these lifestyle approaches to empower our patients. A recent study

done in the US showed that medical students get only 4 hours of training on nutrition and physical activity during their entire 4 years of medical school. That is an astounding fact.

At the Preventive Cardiology department, founded and led by Dr. GR, we have been focusing and addressing the root cause of the disease with a team of Doctors, Registered Dietitians, Physical therapists and other allied health personnel, and marketing team who are passionate about prevention. Consultations are done in an outpatient set-up focusing on primary prevention, treating chronic diseases with evidence based lifestyle therapy along with other uptodate treatment modalities. In-patient services are offered to all patients admitted due to coronary artery disease.

We also have residential intense therapeutic lifestyle treatment options called Heart Awareness and Rehabilitation Program (HARP) where we conduct a 10 day program focusing on diet, physical activity, yoga, relaxation techniques. So far we have conducted 5 such programs, four of them were in hospital settings and one called as an O-HARP (outdoor- Harp) in our PSG retreat center in Anaikatti. It is like jump-starting a car and the focus is given on behavioral modification necessary for sustaining lifestyle changes. It helps patients gain a perspective about being healthy and we give them tools to be successful in implementing changes regarding their health. Patients are followed up with regular visits and our care coordinators do telehealth to make sure there are no fall outs. We can proudly say even during the initial lockdown period, our HARP patients had a virtual group visit with Dr. G. Rajendran - Department of preventive cardiology and the entire team which was greatly appreciated by the patients and their family.

Our mission and vision for the future is not just patient care in a hospital setting. We also have been doing employee wellness programs at corporate set ups and have planned to roll out a program to address obesity in school going children and college students. Another big dream we have is to train the trainees in lifestyle medicine, i.e to develop a curriculum for medical students and residents on lifestyle medicine. Irrespective of our specialty, we all should practice the above elements and empower our patients towards heal “thy” life and thereby build a healthy nation.

I think it is apt here to use Albert Einstein's famous quote that “We cannot solve our problems with the same level of consciousness that we used when we created them”.