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Research Paper

THE HEALTH STATUS OF GERIATRIC POPULATION ATTENDING THE SPECIAL SIDDHA GERIATRIC CLINIC OF A RESEARCH INSTITUTE

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ABSTRACT
Objectives: To assess the morbidity pattern among elderly population attending the special Siddha geriatric clinic. **Study design:** Hospital based cross – sectional study. **Period of Study:** January to December 2009. **Setting:**Special Geriatric Clinic, Siddha Central Research Institute, Chennai.**Study subjects:**1511 elderly peoples having 60+ age including 1070 males and 411 females.**Statistical analysis:** Proportions, chi square test.**Results:**Out of 1511 elderly persons, 1070 (70%) were males & 411 (27%) were females. 1300(86%) were in age group 60-75 years, 196(13%) in age group 76-85 years and 15 (1%) were above 85 years. 1178 (78%) persons were literate.785(52%) persons were vegetarians. 242(16%) persons gave history of regular use of one or more substance(s). 725(52%) persons go for daily morning and/or evening exercise. Co-morbidities were found in 1390(91%) persons who suffered from 2 or more diseases.In Total 113(7.4%) were found to have Tholnoigal 03(0.2%) were found to have PirappurupuNoigal 04(0.26%) were found to have SuraNoigal 300(20%) were found to have VathaNoigal 50(3.3%) were found to have Unavu Mandala Noigal 119(7.88%) were found to have Swasa Mandala Noigal 96(6.35%) were found to have MuthiyorPerumNoigal includes problems. **Conclusion:** As there is less toxicity and more nativity the affinity towards preferences of Siddha is established among geriatrics. The cost effectiveness and palliative care fetches a large group of elderly towards Siddha system. As there is solutions for long term complications, minimal life style changes Siddha focuses a holistic care. Improvement is the quality of life which is documented by good sleep, clear evacuation biological wellbeing including good appetite Siddha is preferred as most.

INTRODUCTION

Geriatrics is the branch of medicine that deals with the diseases of old age. Geriatrics involves treating acute illnesses as well as managing the rehabilitative and long-term care of the aged. As per the 1991 census, the population of the elderly in India was 57 million as compared with 20 million in 1951. There has been a sharp increase in the number of elderly persons between 1991 to 2001 and it has been projected that by the year 2050, the number of elderly people would rise about 324 million (Age Care Statistics)

India has thus acquired the label of "an ageing nation" with 7.7% of its population being more than 60 years old. The demographic transtition is attributed to the decreasing fertility and mortality rates due to the availability of better health care services. *(Irudha Rajan S)*

In India the elderly people suffer from dual medical problems, i.e., both communicable as well as non communicable diseases. This is further compounded by impairment of sensory functions like vision and hearing. A decline in immunity as well as age related physiologic changes leads to an increased burden of communicable diseases in the elderly. The chronic illnesses usually include hypertension, coronoary artery disease and cancer. According to Government of India statistics, cardio vascular disorders account for one third of elderly mortality. Respiratory disorders account for 10% mortalilty while infections including tuberculosis account for another 10%. Neoplasm accounts for 6% and accidents, poisoning and violence constitute less than 4% of the elderly mortality with the more or less similar rates for nutritional , metabolic, gastrointestional and genito urinary infections(Guha)

Indian council of Medical Research ICMR report on the chronic morbidity profile in the elderly states that hearing impairment is the most common morbidity followed by visual impairment.(Shah B

and Prabhakar AK 265-72) However, different studies show varied results in the morbidity pattern.

A Study conducted in the rural area of Pondicherry reported decreased visual acuity due to cataract and refractive errors in 57% of the elderly followed by pain in the joints and joint stiffness in 43.4%, dental and chewing complication in 42% and hearing impairment in 15.4%. Other morbidities were hyper tension(14%), diarrhea(12%),, chronic cough(12%), skin diseases(12%), heart disease (9%), diabetes(8.1%), Asthma(6%) and urinary complaints(5.6%). (Purthy AJ et al. 45-50)

Elderly people who belong to middle and higher income groups are prone to develop obesity and its related complications due to sedentary lifestyle and decreased physical activity. (Ahluwalia N 2-6) India is signatory to Alma-Ata resolution to achieve the goal of health for all by the year 2000 AD and has adopted primary health care approach to strengthen the health delivery system, which has been defined as essential health care made universally accessible to individuals and acceptable to them through their full participation and at a cost the community and country can afford. Though health for all also includes the geriatric population, but scant attention and meagre resource has neglected this group.(WHO(1978) Alma Ata) The geriatric health care is a new concept in India though 20 per cent of doctor visits, 30 per cent of hospital days and 50 per cent of bed-ridden days relate to the elderly.

Most of the elderly do not need institutional care if they are treated early in their illness. They often silently suffer the progression of diseases leading to an abrupt functional decline, which is then wrongly attributed to ageing. Therefore, geriatrics involves treating acute illnesses as well as managing the rehabilitative and long-term care of the aged.

The needs of the elderly are unique and distinctive as they are vulnerable. Health, economic and psychological needs are most important. Among the medical problems, vision (cataract) and degenerative joint disease top the list, followed by neurological, cardiovascular and urinary diseases. Malignant diseases account for a sizeable extent of morbidity. Other problems of concern are malnutrition, frequent falls and cognitive dysfunction. To compound this, the aged often have more than one illness. Elderly patients need a more broad based, inter-disciplinary approach to managing their health as problems are often multi-dimensional - biological, social, emotional, psychological and financial.

Siddha system of medicine is one of the primitive medical systems in India. In Siddha system of medicine, geriatrics is called as “Moopuiyal”. Siddha medicine plays as a major role in maintaining health of the elderly and emphasize immortality.Siddha System of medicine is twined with life style of the elderly as they have a traditional fragrance and native approach. Undoubtedly the strength of Siddha in the context of Geriatric care is **Kaya Karpam therapy,** which is unique because of its ability to promote longevity and influence all aspects of health in a positive way. Describing the effects of Kaya Karpam, the classical texts of Siddha say that from Kaya Karpam one attains longevity, improved harmony and intelligence, freedom from disorder, youthful vigor, excellence of luster, complexion and voice, optimum strength of physique and senses, command over language, respectability and brilliance. (Uthamaroyan C S) A documented statistical report (Govt. of Tamilnadu – ISM directorate - 2008) suggests strength of Geriatric population as beneficiaries stake holding a major share in AYUSH health care deliveries.(Palanichamy and Sathiyarajeswaran 17-22)

Siddha considers the physical structure to be composed of 7 UdalKattugal starting from Rasa and Kaya Karpam is the tool to create premium UdalKattugal (body tissues).The main utility of Kaya Karpam therapy is in functional and degenerative disorders that have a chronic or long standing nature. In such cases, infact, Kaya Karpam is the only solution from the point of view of effective management in any system of medicine. Kaya Karpam becomes more fruitful and effective if it is preceded with suitable purificatory therapy. The reason we see mixed results in many cases where Kaya Karpam is employed is because of the fact that either this purification is not done or improperly done. Bio-cleansing regimen comprising of Kalichal, Vanthi and Anjanam facilitates better bioavailability of the pharmacological therapies, helps to bring about homeostatsis of body-humors, eliminates disease-causing complexes from the body and checks the recurrence and progression of disease. This is effective in managing autoimmune, neurological, psychiatric and musculo-skeletal diseases of chronic and metabolic origin.

MATERIALS AND METHODS

A cross-sectional study of morbidity status of geriatric population in the urban area of Chennaiattending the outpatient department of Siddha Central Research Institute,Chennai. All elderly persons in the age group of 60 years and above were included in the study. There were 1511

persons in the age group of 60 and above (1070 males and 411 females). Each individual in the

study was subjected to personal interview and clinical examination.

The information was collected on a pre-tested Proforma. Each individual was well informed about the study. The purpose of the study was explained and confidentiality of the information was assured.

A detailed history of past and present illness was also taken.

RESULTS

Out of 1511 elderly persons, 1070 (70%) were males &411 (27%) were females. 1300(86%) were in age group 60-75 years, 196(13%) in age group 76-85 years and 15 (1%) were above 85 years. 1178 (78%) persons were literate. (Tab – I)

Tab- I: Socio-demographic profile of study population (n=1511).

	Characteristics	Variables	Number	%
1.	Sex	Male	1070	73
		Female	411	27
2.	Age Group	60 – 75 years	1300	86
		76-85 years	196	13
		>85 years	15	01
3.	Marital Status	Spouse Living	1118	74
		Widower	332	22
		Widow	60	04
		Unmarried	00	00
4.	Literacy	Literate	1178	78
		Illiterate	332	22
5.	Socio Economic status	High	272	18
		Middle	1027	68
		Low	211	14
6.	Living condition in house hold	Alone	150	10
		With Family	195	15
		With Spouse only	375	25
		With spouse and other family members	755	50
7.	Accompanying Person	Came alone	755	50
		Came with spouse	450	30
		Accompanied by family/others	300	20

785(52%) persons were vegetarians. 242(16%) persons gave history of regular use of one or more substance(s). 725(52%) persons go for daily morning and/or evening exercise. Co-morbidities were found in 1390(91%) persons who suffered from 2 or more diseases(Tab – II)

Tab- II: Personal &Behavioural correlates of Elderly Population (n=1511).

	Attributes	Variables	Number	%
1.	Food Habits	Vegetarians	785	52
		Non Vegetarians	725	48
2.	Regular Exercise	Regular exercise	725	52
		No Exercise	785	52
3.	Addiction	One or more substance	242	16
		No Addiction	1269	84
4.	Co Morbidities	1 disease	60	04
		2 disease	589	39
		3 disease	544	36
		>3 disease	257	17
5.	Number of drugs advised	1 drug	60	04
		2 drugs	393	26
		3 drugs	453	30
		>3 drugs	604	40

Table III . Distribution of Elderly as per THOL NOIGAL (SKIN DISEASES)				
S.No	**Diseases**	**Male (n=1070)**	**Female(n=411)`**	**Total(n=1511)**
1.	Kalanjagapadai	40(3.7%)	38(9.3%)	78(5.1 %)
2.	Soori	1(0.09%)	6(1.4%)	7(0.46%)
3.	Karappan	1(0.09%)	0	1(0.06%)
4.	Ovammai	10(0.9%)	4(0.97%)	14(0.92%)
5.	Venpadai	1(0.09%)	12(2.91%)	13(0.86%)
		53(4.9%)	60(14.6%)	113(7.4%)

In Total 113(7.4%) were found to have Tholnoigal includes problems of Kalanjagpadai, Soori, Karappan, Ovammai and Venpadai(Tab- III)

Table IV. Distribution of Elderly as per PIRAPPURUPPU NOIGAL (GENITAL DISORDERS)				
S.No	**Diseases**	**Male (n=1070)**	**Female(n=411)`**	**Total(n=1511)**
1.	Menstrual Disorders	0	1(0.24%)	1(0.07%)
2.	Nocturnal Ejaculation	2 (0.19%)	0	2(0.13%)
		2(0.19%)	1(0.24%)	3(0.2%)

In Total 03(0.2%) were found to have PirappurupuNoigal includes problems of Menstrual disorders and Nocturnal Ejaculation. (Tab –IV)

Table V. Distribution of Elderly as per SURA NOIGAL (FEVERS)				
S.No	**Diseases**	**Male (n=1070)**	**Female(n=411)`**	**Total(n=1511)**
1.	MuraiSuram	1(0.09%)	0	1(0.07%)
2.	ValiIyaSuram	0	3(0.73%)	3(0.2%)
		1(0.09%)	3(0.73%)	4(0.26%)

In Total 04(0.26%) were found to have SuraNoigal includes problems of Muraisuram and ValiIyasuram.(Tab – V)

Table VI. Distribution of Elderly as per VATHA NOIGAL (MUSCULO SKELETAL DISEASES)				
S.No	**Diseases**	**Male (n=1070)**	**Female(n=411)`**	**Total(n=1511)**
1.	OsteoArthritis	46(4.3%)	16(3.9%)	62(4.1%)
2.	VathaDiseases	129(12.0%)	76(18.5%)	205(13.6%)
3.	GoutyArthrits	1(0.09%)	1(0.24%)	2(0.13%)
4.	Hemiplegia	0	4(0.97%)	4(0.26%)
5.	Joint Pain	3(0.28%)	4(0.97%)	7(0.46%)
6.	Back Pain	18(1.7%)	2(0.5%)	20(1.32%)
		197(18.4%)	103(25%)	300(20.0%)

In Total 300(20%) were found to have VathaNoigal includes problems of Osteo arthritis, Vatha diseases, gouty Arthritis, Hemiplegia, joint pain and back Pain.(Tab –VI)

Table VII. Distribution of Elderly as per UNAVU MANDALA NOIGAL (ALIMENTARY SYSTEM DISEASES)				
S.No	**Diseases**	**Male (n=1070)**	**Female(n=411)`**	**Total(n=1511)**
1.	MoolaNoigal	32 (3.0%)	6(1.4%)	38(2.5%)
2.	VairuVali	10(0.9%)	4(0.97%)	11(0.73%)
3.	ValiGunmam	0	1(0.24%)	1(0.07%)
		42(3.92%)	11(2.68%)	50(3.3%)

In Total 50(3.3%) were found to have Unavu Mandala Noigal includes problems of MoolaNoigal, VairuVali and Valigunmam. (Tab – VII)

Table VIII. Distribution of Elderly as per SWASA MANDALA NOIGAL (RESPIRATORY DISESES)				
S.No	**Diseases**	**Male (n=1070)**	**Female(n=411)`**	**Total(n=1511)**
1.	Bronchial Asthma	49 (4.58%)	12(2.9%)	61(4.03%)
2.	Irumal	21(1.96%)	26(6.33%)	47(3.1%)
3.	Peenisam	7 (0.65%)	4(0.97%)	11(0.73%)
		77(7.2%)	32(7.79%)	119(7.88%)

In Total 119(7.88%) were found to have Swasa Mandala Noigal includes problems of Bronchial Asthma, Irumal and Peenisam. (Tab – VIII)

Table IX. Distribution of Elderly as per MUTHIYOR PERUM NOIGAL (GERIATRIC MAJOR AILMENTS)				
S.No	**Diseases**	**Male (n=1070)**	**Female(n=411)`**	**Total(n=1511)**
1.	Diabetes	44 (4.11%)	40 (9.73%)	84(5.56%)
2.	Cardiac Diseases	7(0.65%)	3(0.73%)	10(0.66%)
3.	Eye Diseases	1(0.09%)	1(0.24%)	2(0.13%)
		52(4.85%)	44(10.7%)	96(6.35%)

In Total 96(6.35%) were found to have MuthiyorPerumNoigal includes problems of Diabetes, Cardiac diseases and Eye diseases. (Tab- IX)

DISCUSSION

There are 933 women per 1000 men in India, But in age group ≥ 60 years there are 100 women for every 88 men (Sample Registration System Estimates of India, 2003).There is no vast ratio in the head count of genders but the awareness on health issues is poor among the female population which is reflected in the attendance.(M:F::73:27). A social stigma still exists and gender issues or still predominant which straightly affects the health care of females and this is happening as a wanted deletion.

In an urban set-up literacy status of elderly is high (78%).Even though there chances of frequent falls, the lonely attendance of elderly either may be due neglect or due their increased confidence level. Half of them attended the clinic on their own without any attendant.

Morbidity load was found to be 2.92 illnesses per person in this study which is more than that found by(Shankar R, Tandon J, and et.al 56-58) (2.18 illnesses per person) and (Padda AS and Mohan V 76-77) (2.55 illnesses per person) in their studies. But the it is similar to findings of (Sharma AL 16-20) frequency of illness which varies from 2.5 to 3.5 illnesses per person.

Similar to finding of (Bhatia SPS and Swami HM) 91% had one or more health related problems. Co-morbidities (with 2 or more diseases) were common among 1390(91%) persons which is coherent with finding of the (National Sample Survey Organisation (NSSO) 1-2) carried out by Govt. of India in 1986-87.

In a community based study carried out in South India by ICMR in 1984,(Rao AV) major causes of morbidity enumerated were Visual Impairment (88%),Locomotor Disabilities(40%),Neurological disorder(18.7%), Cardiovascular disorder(16.1%) and Skin diseases(13.3%). In our clinic based hospital study on urban elderly, major health problems were VathaNoigal(20%), Swasa mandala Noigal(7.8%), TholNoigal (7.4%), MuthiyorPerumNoigal(6.3%) followed by Unavu Mandala Noigal and Pirappuruppunoigal and suranoigal

Being a native medical system the limitations and strength are known and also the inculcated of insecurity of Siddha system in surgical as well as cardiac care, limits the elderly to fix only with allopathic system which is reflected in the less attendance in Visual impairment and Cardiovascular disorders. Their understanding gave a confidence level to treat themselves for chronic disease in Siddha system owing to the benefit of negligent side effects. 20% attendance in Vathanoigal supports this.

There is a paradigm shift of elderly towards Siddha system as the medications given are safe and can be used for prolonging period along with the regular drugs they use. But the multiple drugs given in western system many a times make them to report

adverse effects and this is major point of reference to Siddha physician by an allopath

CONCLUSION

As there is less toxicity and more nativity the affinity towards preferences of Siddha is established among geriatrics. The cost effectiveness

and palliative care fetches a large group of elderly towards Siddha system. As there is solutions for long term complications, minimal life style changes Siddha focuses a holistic care. Improvement is the quality of life which is documented by good sleep, clear evacuation biological wellbeing including good appetite Siddha is preferred as most.

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