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AKADEMİK GERİATRİ DERNEĞİ

INTERNATIONAL ASSOCIATION OF GERONTOLOGY AND GERIATRICS
Founded 1950

ULUSLARARASI
AKADEMİK GERİATRİ KONGRESİ 2017

12 – 16 Nisan 2017 | Calista Otel | Antalya

BİLDİRİ ÖZETLERİ

www.**akademikgeriatri2017**.org

AKADEMİK GERİATRİ DERNEĞİ

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SERENAS

ORGANİZASYON SEKRETERYASI

Serenas Uluslararası Turizm Kongre Organizasyon A.Ş.
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İÇİNDEKİLER

DAVET

Değerli Meslektaşlarım,

"Uluslararası Akademik Geriatri Kongresi 2017", Akademik Geriatri Derneği tarafından 12 – 16 Nisan 2017 tarihlerinde Calista Otel, Belek / Antalya 'da gerçekleştirilecektir. Derneğimizce kongreyi Uluslararası boyuta taşıyarak hem bilimsel seviyeyi yükseltmek, hem de akademik çalışmalara destek vermek amacındayız.

Ülkemizde yaşlı nüfus 2016 verilerine göre % 8,2'dir ve diğer yaş gruplarına göre daha yüksek bir hızla artmaktadır, yani Türkiye'de 6,5 milyon civarında yaşlı birey bulunmaktadır. Bütün bu veriler her basamak ve branştaki hekimin daha sık yaşlı hasta ile karşılaşacağı anlamına gelmektedir.

Demans, depresyon, deliryum, inkontinans, bası yaraları, malnütrisyon, sarkopeni, polifarmasi, düşmeler, osteoporoz, kırılganlık başlıca Geriatrik Sendromlar olup, güncel yaklaşımlarla kongre programında yer alacaktır. Diyabet, hipertansiyon, hiperlipidemi, atrial fibrilasyon, Parkinson, osteoartrit, ağrı, enfeksiyonlar gibi yaşlıda sık görülen hastalıklarda kongrede değişik yönlerden tartışılacaktır. Birinci basamak hekimlerinin yaşlı hasta ile ilgili sorunları, huzurevi ve bakımevi çalışanlarının sık karşılaştığı problemler de bu kongrenin temel konularıdır.

İnterdisipliner ekip anlayışı içinde multidisipliner bir yaklaşımı amaçlayan Geriatri Biliminin amacına uygun olarak farklı disiplinlerden konuşmacılar ve konularla, yaşlı sağlığına kapsamlı bir bakış ve güncelleme sunulacaktır. Kongrenin Uluslararası olmasının Geriatrik olgu sunumları ve sözel bildirileri daha bilimsel boyuta taşıyacağı ve sunum yapanların akademik çalışmalarına fayda sağlayacağı düşünülmektedir.

Yaşlı sağlığı ile ilgilenen başta geriatristler olmak üzere, iç hastalıkları uzmanları, aile hekimleri ve uzmanları, nöroloji uzmanları, psikiyatri uzmanları, fizik tedavi uzmanları, huzurevi ve bakım evi hekimleri, hemşire, fizyoterapist ve diyetisyenler bu kongrenin hedef kitlesidir.

Düzenleme kurulu olarak siz değerli katılımcılarımıza kaliteli bir bilimsel program sunmak, akademik çalışmalarınıza destek olmak arzusundayız. Sizleri aramızda görmekten mutluluk duyacağız.

Saygılarımla,

Dr. Hüseyin DORUK

Kongre Başkanı

KURULLAR

DÜZENLEME KURULU

Kongre Başkanı

Dr. Hüseyin Doruk

Düzenleme Kurulu

Dr. Ergün Bozoğlu
Dr. İlkin Naharcı
Dr. Mehmet Akif Karan
Dr. Deniz Suna Erdinçler
Dr. Teslime Atlı
Dr. Meltem Halil
Dr. Murat Varlı
Dr. Gülistan Bahat Öztürk
Dr. Zeynep Dilek Aydın
Dr. Zeynel Abidin Öztürk
Dr. Aslı Tufan

BİLİMSEL KURUL

Dr. Fehmi Akçiçek *(TR)*
Dr. Sibel Akın *(TR)*
Dr. Sevgi Aras *(TR)*
Dr. Volkan Atmış *(TR)*
Dr. Burcu Balam Yavuz *(TR)*
Dr. Tanju Beğer *(TR)*
Dr. Ergün Bozoğlu *(TR)*
Dr. Mustafa Cankurtaran *(TR)*
Dr. Alfonso Cruz-Jentoft *(SPAIN)*
Dr. Erkan Çoban *(TR)*
Dr. Aslı Çurgunlu *(TR)*
Dr. Ali Asghar Danesh *(USA)*
Dr. Hüseyin Doruk *(TR)*
Dr. Alper Döventaş *(TR)*
Dr. Gabriella Engstrom *(USA)*
Dr. Doron Garfinkel *(ISRAEL)*
Dr. Özlem Karaarslan Cengiz *(TR)*
Dr. Berrin Karadağ *(TR)*
Dr. Yalçın Kepekçi *(TR)*
Dr. Milta Oyola Little *(USA)*
Dr. İlkin Naharcı *(TR)*
Dr. Selim Nalbant *(TR)*
Dr. Graziano Onder *(ITALY)*
Dr. Saban Hakki Onen *(FRANCE)*
Dr. Joseph G. Ouslander *(USA)*
Dr. Hilal Özkaya *(TR)*
Dr. Connie Porcaro *(USA)*
Dr. Bülent Saka *(TR)*
Dr. Fulden Saraç *(TR)*
Dr. Sumru Savaş *(TR)*
Dr. Sevnaz Şahin *(TR)*
Dr. Ruth Tappen *(USA)*
Dr. İlker Taşçı *(TR)*
Dr. Ender Terzioğlu *(TR)*
Dr. Pınar Tosun Taşar *(TR)*
Dr. Pemra Ünalan *(TR)*
Dr. Ahmet Yalçın *(TR)*
Dr. Hakan Yavuzer *(TR)*
Dr. Mehmet Yürüyen *(TR)*
Dr. Vildan Kandemir *(TR)*

ÖDÜL DEĞERLENDİRME KOMİTESİ

Dr. Deniz Suna Erdinçler
Dr. Selim Nalbant
Dr. Hüseyin Doruk
Dr. Teslime Atlı
Dr. Meltem Halil
Dr. Gülistan Bahat Öztürk
Dr. Murat Varlı
Dr. Zekeriya Ülger
Dr. Sevnaz Şahin

1. gün	12 Nisan 2017 - ÇARŞAMBA
Saat	**SALON A**
14:00-14:45	**Panel 1: Ulusal Bakım Göstergeleri Prevalans Çalışması (LPZ Study);** **Bşk: Dr. Deniz Suna Erdinçler, Dr. Zeynel Abidin Öztürk** ***Dr. Bülent Saka***
14:45-15:00	**ARA**
15:00-16:00	**UYDU 1** Konu; **Protokolün Ön Sırası Protein** Moderatör; ***Dr. Suna Deniz Erdinçler*** Konuşmacı; ***Dr. Teslime Atlı*** NestléHealthScience
16:00-16:15	**ARA**
16:15-17:15	**Panel 10: Disfaji Nasıl Tanıyalım-Nasıl Yönetelim?** **Bşk: Dr. Gülistan Bahat Öztürk, Dr. Meltem Halil** - Kırılgan Yaşlı ve Disfaji: Geriatri Deneyimi ***Dr. Gülistan Bahat Öztürk*** - Yaşlıya Özel: Klinikte Pratik Disfaji Değerlendirmesi ve Yönetimi ***Dr. Sibel Eyigör*** - Serebrovasküler Olay İlişkili Disfajiye Yaklaşım: Akut Dönem ve Sonrası ***Dr. Yakup Krespi***
17:15-17:30	**ARA**
17:30-18:00	**AÇILIŞ TÖRENİ**
18:00-19:00	**Panel 3: Yaşlı Sağlığı Politikaları** **Başkan: Dr. Cevdet Erdöl, Dr. Vural Kavuncu** - Yaşlı Sağlığı Politikaları ve Kamu Hastaneleri ***Dr. Alper Cihan*** - Sağlıklı Yaşlanma Eylem Planı ***Dr. Bekir Keskinkılıç***

BİLİMSEL PROGRAM

2. gün	13 Nisan 2017 - PERŞEMBE
Saat	**SALON A**
08:30-09:45	**Panel 4: Yaşlılarda Kardiyovasküler Sorunlar** **Bşk: Dr. Dursun Aras, Dr. Sinan Aydoğdu** - Kalp Yetmezliği, ***Dr. Özcan Özeke*** - Aritmiler, ***Dr. Dursun Aras*** - Yaşlıda YOAK Kullanımında Sorunlar, ***Dr. Sinan Aydoğdu***
09:45-10:10	**ARA**
10:10-11:00	**Panel 6: Yaşlıda Nazokomiyal Enfeksiyonları** **Bşk: Dr. Ali Mert, Dr. Sibel Akın** - Üriner Sistem İnfeksiyonu, ***Dr. Ferhat Arslan*** - Pnömoni, ***Dr. Ahmet Öztürk*** - Kateter ve PEG/PEJ İlişkili Enfeksiyonlar, ***Dr. Mesut Yılmaz***
11:10-11:30	**ARA**
11:30-12:30	**UYDU 2** **Osteoporozda Anabolik Tedavi: Kime ve Ne Zaman?** Oturum Başkanı: ***Dr. Deniz Suna Erdinçler*** Konuşmacı: ***Dr. Dilek Gogas Yavuz***
12:30-13:30	**ÖĞLE YEMEĞİ**
13:30-14:30	**Panel 8: Kardiyovasküler Risk Faktörlerinin Yönetimi** **Bşk: Dr. Tufan Tükek, Dr. Burcu Balam Yavuz** - HT ve Hedefler, ***Dr. Kenan Sağlam*** - Hiperlipidemi ve Hedefler, ***Dr. Kerim Güler*** - DM ve Hedefler, ***Dr. Coşkun Meriç***
14:30-15:30	**UYDU 3** **Yaşlıda Malnütrisyon Tedavisi** Moderatör: ***Dr. Bülent Saka*** **Tanı ve Tedavide Neler Değişti?** ***Dr. Meltem Halil*** **Kronik Hastalıklarda Nütrisyon Tedavisi** ***Dr. Bülent Saka***
15:30-16:00	**ARA**
16:00-17:00	**Panel 2: Kırılganlık ve Risk Değerlendirmesi** **Bşk: Dr. Sevnaz Şahin** - Kanser Hastasında, ***Dr. Öznur Büyükturan*** - Cerrahi Hastasında, ***Dr. Sibel Akın*** - Akut Hastalıklarda, ***Dr. Hakan Yavuzer***
17:00-17:30	**ARA**
17:30-18:30	**YUVARLAK MASA TOPLANTILARI**

2. gün	13 Nisan 2017 - PERŞEMBE
Saat	**SALON B**
08:30-09:45	**Panel 5: Yaşlıda Polifarmasi ve Uygunsuz İlaç Kullanımı Epidemisi: Çoklu ilaç Kullanımını Nasıl Yönetelim?** **Bşk: Dr. Mehmet Akif Karan, Dr. Gülistan Bahat-Öztürk** - 21. yy İatrojenik Epidemisi: Uygunsuz İlaç Kullanımı ve Polifarmasi, ***Dr. Gülistan Bahat Öztürk*** - IMUP Azaltımı için Önerilen Metodlar, ***Dr. Mehmet İlkin Naharcı*** - Yaşlıda İlaç Kesmek: Güvenli mi? Yararlı mı? , ***Dr. Gülistan Bahat Öztürk***
09:45-10:10	**ARA**
10:10-11:00	**Panel 7: Hastanenin Yaşlı ile İmtihanı** **Bşk: Dr. Servet Arıoğul, Dr. Mehmet İlkin Naharcı** - Deliryum, ***Dr. Sevgi Aras*** - Düşme, ***Dr. Burcu Balam Yavuz*** - Komplikasyon Yönetimi, ***Dr. Alper Döventaş***
11:10-11:30	**ARA**
11:30-12:30	
12:30-13:30	**ÖĞLE YEMEĞİ**
13:30-14:30	**Panel 9: Bası Yaralarına Yaklaşım** **Bşk: Dr. Hüseyin Doruk, Dr. Sevgi Aras** - Koruyucu Yaklaşım, ***Dr. Murat Varlı*** - Medikal Tedavi, ***Dr. Berrin Karadağ*** - Cerrahi Tedavi, ***Dr. Asım Aydın***
14:30-15:30	
15:30-16:00	**ARA**
16:00-17:00	**Panel 11: Yaşlı ve Kaliteli Yaşam** **Bşk: Dr. Tanju Beğer, Dr. İlker Taşçı** - Yaşlıda Ağız ve Diş Sağlığı, ***Dr. Kerem Kılıç*** - Konstipasyonda Yeni Yaklaşımlar, ***Dr. Özdal Ersoy*** - İleri Bakım Uygulamaları, ***Dr. Mehmet İlkin Naharcı***
17:00-17:30	**ARA**
17:30-18:30	**YUVARLAK MASA TOPLANTILARI**

3. gün	14 Nisan 2017 - CUMA
Saat	**SALON A**
08:30-09:45	**Panel 12: Alzheimer Hastalığında Yeni Gelişmeler** **Bşk: Dr. Yalçın Kepekçi, Dr. Ergün Bozoğlu** - Biyomarkerlar, ***Dr. Haşmet Hanağası*** - Görüntüleme, ***Dr. Bilge Volkan*** - AH Nörogörüntüleme ile Kognitif Testlerin Karşılaştırılması, ***Dr. Meltem Halil*** - AH Tedavisinde Güncel Durum, ***Dr. Mustafa Cankurtaran***
09:45-10:10	**ARA**
10:10-11:10	**Panel 14: Yaşlı Hastada KOAH: Farklılıklar ve yenilikler** **Bşk: Dr. Mecit Süerdem, Dr. Teslime Atlı** - KOAH Tanısında Farklılıklar ve Yenilikler, ***Dr. Arzu Ertürk*** - KOAH Tedavisinde Farklılıklar ve Yenilikler (GOLD'da değişenler), ***Dr. Mecit Süerdem*** - KOAH'lı Yaşlı Hastanın Takibinde Farklılıklar ve Yenilikler, ***Dr. Funda Coşkun***
11:11-11:30	**ARA**
11:30-12:30	**UYDU 4** **Zorlu Diyabet Yolunda Sağlam Başlangıç** **Farklı Bir DPP4 İnhibitörü Linagliptin** Konuşmacı: ***Dr. Mustafa Araz*** Boehringer Ingelheim
12:30-13:30	**ÖĞLE YEMEĞİ**
13:30-14:30	**Panel 16: Yaşlıda Diabet Tedavisinde Yeni Yaklaşımlar** **Bşk: Dr. Mustafa Kutlu, Dr. Alper Döventaş** - Yeni OAD ve Diğerleri, ***Dr. Özgür Demir*** - Yeni İnsülinler, ***Dr. Fulden Saraç***
14:30-15:30	**UYDU 5** **'Kas Kaybının Önemi ve Aktif Nütrisyon'** Moderatör: ***Dr. Mehmet Akif Karan*** Konuşmacı: ***Dr. Meltem Halil*** Abbott
15:30-16:00	**ARA**
16:00-17:00	**Panel 18: Yaşlıda Yaygın Ağrı Tabloları** **Bşk: Dr. Nur Kesiktaş, Dr. Fulden Saraç** - PMR ve Temporal Arterit, ***Dr. Gökhan Keser*** - Yaygın Yumuşak Doku Ağrıları, ***Dr. Ayşe Karan***
17:00-17:30	**ARA**
17:30-18:00	**KAPANIŞ VE ÖDÜL TÖRENİ**
18:00-19:00	**AKADEMİK GERİATRİ DERNEĞİ OLAĞAN GENEL KURULU**

3. gün	14 Nisan 2017 - CUMA
Saat	**SALON B**
08:30-09:45	**Panel 13: Terminal Hastada Semptomların Palyasyonu** **Bşk: Dr. Bülent Saka, Dr. Murat Varlı** - Ağrı, ***Dr. Mehmet Yürüyen*** - GİS Semptomları, ***Dr. Ümit Aydoğan*** - Geriatrik Palyatif Bakımın Özellikleri, ***Dr. Sevnaz Şahin***
09:45-10:10	**ARA**
10:10-11:10	**Panel 15: Yaşlılık ve Hayat** **Bşk: Dr. Mustafa Cankurtaran, Dr. Berrin Karadağ** - Trafik (Yaşlı Sürücüler), ***Dr. Tolga Taymaz*** - Yaşlıda Fiziksel Aktivite, ***Dr. Meltem Vural*** - Yaşlıda Yürüme Analizi, ***Dr. Bayram Kaymak***
11:11-11:30	**ARA**
11:30-12:30	
12:30-13:30	**ÖĞLE YEMEĞİ**
13:30-14:30	**Panel 17: Demanslı Hastalardaki Sorunlar** **Bşk: Dr. Selim Nalbant, Dr. Dilek Aydın** - Uyku Bozuklukları, ***Dr. Hasan Öztin*** - Davranış Bozuklukları, ***Dr. Özlem Karaaslan*** - İnkontinans, ***Dr. Ergün Bozoğlu***
14:30-15:30	
15:30-16:00	**ARA**
16:00-17:00	**Panel 19: Yaşlı Bakım Modellerinde Evde Bakımın Önemi** **Bşk: Aynur Dik, Dr. Aslı Curgunlu** - Ülkemizde Evde Sağlık / Bakım Hizmetleri Uygulamaları, Sorunları ve Çözüm Önerileri ***Aynur Dik*** - Yaşlılara Yönelik Alternatif Evde Sağlık/Bakım Modelleri, ***Dr. Sema OĞLAK*** - Yaşlıların Evde Bakımında Bilişim ve Teknolojinin Kullanımı, ***Ferhat Şayeste***
17:00-17:30	**ARA**
17:30-18:00	
18:00-19:00	**AKADEMİK GERİATRİ DERNEĞİ OLAĞAN GENEL KURULU**

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<tr><th>4. gün</th><th>15 Nisan 2017 - CUMARTESİ</th></tr>
<tr><th>Saat</th><th>SALON A</th></tr>
<tr><td>09:00-10:30</td><td>Kurs 1: Nutrisyon ;
Koordinatörler: Dr. Bülent Saka, Dr. Meltem Halil, Dr. Ergün Bozoğlu
- Malnütrisyon Tanısı, Dr. Berrin Karadağ
- Enteral Beslenme, Dr. Volkan Atmış
- Parenteral Beslenme, Dr. Cemal Kızılaslanoğlu</td></tr>
<tr><td>10:30-11:00</td><td>ARA</td></tr>
<tr><td>11:00-12:00</td><td>- Sarkopeni, Dr. Ergün Bozoğlu
- Kanserde MN Tedavisi, Dr. Meltem Halil
- Yeni Kılavuzlar ile Ne Değişti ?, Dr. Bülent Saka</td></tr>
<tr><td>12:00-13:30</td><td>ÖĞLE YEMEĞİ</td></tr>
<tr><td>13:30-15:00</td><td>MN Tedavisinde Pratik Yaklaşımlar, Hemşire Kezban Akçay
Eczacı Burcu Kelleci</td></tr>
<tr><td>15:00-15:30</td><td>ARA</td></tr>
<tr><td>15:30-17:00</td><td>İnteraktif Vaka Tartışmaları (4 Masa / 4 Vaka)</td></tr>
<tr><td></td><td>VAKA 1 : DEMANS / DİSFAJİ, Dr. Bülent Saka
VAKA 2 : BASI YARASI, Dr. Gülistan Bahat Öztürk
VAKA 3 : KANSER, Dr. Meltem Halil
VAKA 4 : ÇOKLU KOMORBİDİTE (DM, KBY, KKY, HEMODİYALİZ ?), Dr. Abidin Öztürk</td></tr>
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<tr><th>GRUP 1</th><th>GRUP 2</th><th>GRUP 3</th><th>GRUP 4</th></tr>
<tr><td>V.1</td><td>V.2</td><td>V.3</td><td>V.4</td></tr>
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<tr><td>V.4</td><td>V.1</td><td>V.2</td><td>V.3</td></tr>
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4. gün	15 Nisan 2017 - CUMARTESİ
Saat	**SALON B**
09:00-10:30	**Kurs 3: Olgu Örnekleri ile Parkinson ;** **Koordinatörler: Dr. Cenk Akbostancı, Dr. Murat Varlı** - Olgu örnekleri ile Parkinson Hastalığı Tanısı ve Ayırıcı Tanısı, ***Dr. Serhat Özkan*** - Olgu örnekleri ile Parkinson Hastalığının Motor Semptomlarının Tedavisi, ***Dr. Okan Doğu***
10:30-11:00	**ARA**
11:00-12:00	- Olgu Örnekleri ile Parkinson Hastalığının Non-Motor Semptomlarının Tedavisi ***Dr. Cenk Akbostancı*** - Sorular ve Tartışma
12:00-13:30	**ÖĞLE YEMEĞİ**
13:30-15:00	
15:00-15:30	**ARA**
15:30-17:00	

YUVARLAK MASA TOPLANTILARI

Gün	13 Nisan 2017 Perşembe	
Saat	**SALON A**	**SALON B**
17:30-18:30	**1. Bakım Hizmetlerinde Son Durum :** Kurumsal Bakımda Sorunlar? Evde Bakımda Sorunlar? Yaşlı Bakıcılığı? İnterdisipliner Ekip Çalışmasının Sıkıntıları? **Başkanlar:** Dr. Vildan Kandemir, Dr. Pemra Ünalan, Dr. Nil Tekin **Katılımcılar:** 1. Mehmet İlkin Naharcı 2. Hilal Özkaya 3. Berrin Karadağ 4. Murat Varlı 5. Ahmet Fırat Küçükköse 6. Ahmet Yalçın 7. Güneş Arık 8. Aslı Tufan 9. Nilay Şahin	**2. Acilde yaşlı hasta:** Yaşlıya Farklı mı Davranıyoruz? Sık Rastlanan Tanılar? Gözden Kaçırılanlar? Acilde Kapsamlı Değerlendirme? Acil Cerrahi Girişim Kararı**?** **Başkanlar:** Dr. Kerim Güler, Dr. Tufan Tükek, Dr. Tolga Taymaz, Dr. Pamir Erdinçler, Dr. Dursun Aras. **Katılımcılar:** 1. Fulden Saraç 2. Sevgi Aras 3. Tolga Taymaz 4. Remzi Bahşi 5. Sadık Gümüş 6. Mustafa Kemal Kılıç 7. Hasan Öztin 8. Sumru Savaş

Gün	13 Nisan 2017 Perşembe		
Saat	**SALON C**	**SALON D**	**SALON E**
17:30-18:30	**3. Yaşlıda Yatak Başı Değerlendirme** : Kognitif Değerlendirme Psikiyatrik Değerlendirme **Başkanlar:** Dr. Işın Baral Kulaksızoğlu, Dr. Ergün Bozoğlu **Katılımcılar:** 1. Özlem Karaarslan Cengiz 2. Bülent Saka 3. Suna Avcı 4. Banu Özulu Türkmen 5. Birkan İlhan 6. Tuğba Turgut 7. Rana Tuna Doğrul 8. Aslı Kılavuz	**4. Yaşlıda Görme Problemleri :** **Başkanlar:** Dr. Olcay Tatar, Dr. Meltem Halil **Katılımcılar:** 1. Selim Nalbant 2. Volkan Atmış 3. Cemile Özsürekçi 4. Özge Kayhan Koçak 5. Firuzan Fırat Özer 6. Deniz Mut Sürmeli 7. Alper Döventaş 8. Hüseyin Doruk 9. Fatih Sümer 10. Cafer Balcı	**5. Reducing Polypharmacy and IMU in your own clinic : Real case discussions** (Uygunsuz ilaç Kullanımı ve Polifarmasi ile Nasıl Başa Çıkalım?: Gerçek Hasta Örnekleriyle Tartışma) **Başkanlar**: Dr. Gülistan Bahat Öztürk, Dr. Mehmet İlkin Naharcı **Katılımcılar:** 1. Sibel Akın 2. Hülya Kuşoğlu 3. Hacer Doğan Varan 4. Burcu Balam Yavuz 5. M. Cemal Kızılraslanoğlu 6. Ahmet Öztürk 7. Mehmet Yürüyen

ORAL PRESENTATIONS LIST

13 NİSAN 2017, PERŞEMBE
SALON C / 10:10-11:10

OP-01

THE EFFECT OF CPAP THERAPY ON COGNITIVE FUNCTIONS INPATIENTS OVER60YEARSOLD WITH MODERATE TOSEVERE OBSTRUCTIVESLEEPAPNEA
Aslı Tufan

OP-02

IMPACT OF EXERCISE ON QUALITY OF LIFE, BODY AWARENESS, KINESIOFOBIA AND FALLING IN ELDERLY: RANDOMIZED CONTROLLED STUDY
Arzu Erden

OP-03

THE INVESTIGATION OF SPINAL MOBILITY IN OLDER ADULTS WITH CHRONIC LOW BACK PAIN: A PILOT STUDY
Öznur Büyükturan

OP-04

THE EFFECT OF THE DRUG ADMINISTRATION AND EXERCISE ON SYMPTOMS AND HAPPINESS LEVEL IN YOUNGER ELDERLY
Seçil Gülhan Güner

OP-05

EFFECTS OF AEROBİC EXERCİSE İN AN OLDER ADULT WİTH CHRONİC MAJOR DEPRESSİVE DİSORDER WHO UNTREATED WİTH PHARMACOTHERAPY
Öznur Büyükturan

OP-06

LET'S DİAGNOSE SARCOPENİA WİTH A DEEP BREATH
Olgun Deniz

13 NİSAN 2017, PERŞEMBE
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ULUSLARARASI AKADEMİK GERİATRİ KONGRESİ

2017

ORAL PRESENTATIONS

OP-01

THE EFFECT OF CPAP THERAPY ON COGNITIVE FUNCTIONS INPATIENTS OVER60YEARSOLD WITH MODERATE TOSEVERE OBSTRUCTIVESLEEPAPNEA

Aslı Tufan[1], Gülistan Bahat[2], Deniz Büyükgök[3], Züleyha Bingöl[4], Esen Kıyan[4], Raim İliaz[5], Mehmet Akif Karan[2]

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Introduction: Obstructive sleep apnea (OSA) characterizes apneas and hypopneas during sleep. Daytime sleepiness and cognitive dysfunction were reported in untreated OSA patients. However, the effect of Continuous Positive Airway Pressure (CPAP) treatment on cognitive functions, daily life activities, depression, anxiety and quality of life in elderly is unknown. The aim of our study was to investigate the effect of CPAP treatment on the parameters of the OSA patients over 60 years of age.

Method: ESS (Epworth Sleepiness Score), AHI (apnea-hypopnea index), ODI (oxygen desaturation index), sleeping SpO2<90% of patients >60 years old with moderate to severe OSA who applied to the pulmonary diseases outpatient clinic between May 2014-January 2015 were recorded. At least 5 days/week-at least 4 hours/day using CPAP, was accepted as compatible to treatment.

Neuropsychological assessment was performed before CPAP treatment and after 3-months of CPAP. Digit span forward-backward, semantic-phonemic verbal fluency, trail test, stroop test, visiospatial perception, instant-delayed story memory, instant memory and learning score were determined. Functionality was evaluated using Katz activities of daily living and Lawton instrumental activities of daily living scores, depression by geriatric depression scale, anxiety by STAI anxiety scale, and quality of life by EQ5 test. Baseline values were compared with values after 3 months of effective CPAP use.

Results: Thirty patients included to the the study. Analysis was completed on 16 patients due to device incompatibility and follow-up drop (Table 1). After 3-month CPAP result in significant improvements in clock drawing test, recognition, instant memory and learning scores (Table 2)

Conclusion: In our study, 3-month CPAP treatment improved executive functions (attention and planning) in patients. The results of our study suggest that CPAP therapy is effective in preventing cognitive impairments in older OSA patients.

Keywords: continuous positive airway pressure, neuropsychological assessment, obstructive sleep apnea, older adults.

Table 1. Demographic features of patients (n=16).

Age (years)	[64.8±4.9] (60-78)
Gender (female/male)	[8/8]
BMI (kg/m²)	[32.9±6.3] (24-49)
Snoring	16 (100%)
Apnea	11 (69%)
Day time sleepness	11 (69%)
ESS	[6.3±4.7] (1-18)
AHI score (number/hour)	[39.1± 19] (15-95)
OSA (moderate)	6 (37%)
OSA (severe)	10 (63 %)
ODI (number/hour)	[39.3 ±21.8] (16-96)
Min. O2 Sat (%)	[77.4±9.4] (50-89)
Average O2 sat (%)	[93.4±1.7] (90-96)
SpO2< 90% time (seconds)	[6.5±8.3] (0-27)

Comorbities

• Hypertension	12 (75%)
• Diabetes Mellitus	4 (25%)
• Coronary artery disease	6 (38%)
• Asthma	1 (6.3%)
• Depression	3 (19%)

[mean±SD] (min-maximum)
SD: standart deviation
BMI: Body Mass Index
AHI: Apnea-Hipopnea Index
ESS: Epworth Sleepness Score
ODI: Oxygen Desaturation Index

Table 2. Evaluation of neuroptychological scores baseline and after 3 months of CPAP treatment use.

	0.month	3.month	p
Digit span forward (number)	4.88± 0.72 (5)(3-6)	4.62± 0.95 (5)(3-6)	0.157
Digit span backward (number)	3.31±0.79 (3.5)(2-4)	3.31±0.79 (3.5) (2-4)	1
Semantic fluency (number)	16.80±4.52	18.26±5.96	0.250
Phonemic fluency (number)	26.84±13.30	27.84±13.06	0.515
Trail making A (sec)	75.72±29.71	66.90±21.54	0.129
Trail making difference (B-A) (sec)	127.54±85.40	136.27±61.28	0.674
Stroop Test (sec)	57.61±28.64	58.30±48.03	0.938
Clock drawing test (score)	4.67±0.62(5)(3-5)	4.92±0.26 (5)(4-5)	**0.046***
Visiospatial perception (score)	20.7±2.79(20.5)(17-25)	19.78±2.04(20)(17-22)	0.343
Instant story memory (%)	47.0±10.8	44.9±10.6	0.700
Delayed story memory(%)	46.8±8.2	45.6±11.8	0.690
GDS (score)	5.53±5.95(3)(0-19)	3.92±3.68(3)(0-12)	0.445
Instant anxiety score	35.92±8.31 (34.5)(24-50)	31.07±8.04 (29) (22-46)	0.075
General anxiety score	44.00±9.37	43.00±9.24	0.791
Immediate recall (score)	7.00±2.50	8.25±2.04	**0.048***
Learning score	48.68±12.69	54.87±7.84	**0.021***
Delayed free recall (score)	10±2.73 (10)(5-14)	10.53±1.59 (11)(7-14)	0.547
Recognition (score)	15.12±0.88 (15)(13-16)	15.62±0.5(16)(15-16)	**0.033***
ADL (score)	18±0	18±0	1
IADL(score)	23.63±1.2 (24)(20-24)	23.46±1.19(24)(20-24)	0.317
EQ5 (score)	6.9±1.28(6.5)(5-9)	6.28±1.26(6)(5-9)	0.238

OP-02

IMPACT OF EXERCISE ON QUALITY OF LIFE, BODY AWARENESS, KINESIOFOBIA AND FALLING IN ELDERLY: RANDOMIZED CONTROLLED STUDY

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Karadeniz Technical University Faculty Of Health Sciences

Purpose: This study was planned to examine the effect of exercise on quality of life, body awareness, kinesiofobia and falling risk among elderly.

Methods and Materials: The study was performed with 76 elderly aged over 65 years in Trabzon. Participants were divided into two groups: study group that applied exercise program (36) and control group included non-exercising individuals (38). 12-week exercise program was applied to the study group. We used SF-36 Quality of Life Questionnaire to evaluate quality of life, Body Awareness Quastionaire Scale (BAQ) for comparison awareness condition, Tampa Kinesiophobia Scale (TKS-11) for perception of kinesiophobia, Denn Falling Risk Scale was used to determine falling risk level. Age, gender, body mass index, educational status, marital status, family structure, income level, living with people, smoking and alcohol use, chronic illness were questioned with sociodemographic data form.

Results: The mean age of the patients is 69,45 ±0,43 years. %45,9 percent of participents were obese, 31,1 percent were lightweight, 23.0 percent were normal. The mean of body awareness level was 89,96±15,91 , the mean score of kinesiophobia scale was 27,42±3,89, the mean of falling risk level was 6,28±3,76. There were differences in terms of quality of life in all subscales, body awearenes level (p<0,05) and no differences in terms of kinesiophobia, falling risk level between two groups (p= 0,37 p=0,52).

Conclusion: The presence of positive effects on quality of life and body awareness in elderly will shed light on planning geriatric rehabilitation program for health professions.

Keywords: Exercise, Elderly, Kinesiophobia, Body Awareness.

OP-03

THE INVESTIGATION OF SPINAL MOBILITY IN OLDER ADULTS WITH CHRONIC LOW BACK PAIN: A PILOT STUDY

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Purpose: Low back pain (LBP) is the term used to indicate lumbosacral pain originating from an area between the bottom of the twelfth rib and above the gluteal fold. The prevalence of chronic LBP is approximately 23% in older adults. The purpose of this study is to compare the spinal mobility in older adults with and without chronic LBP.

Materials and Methods: Fifteen older adults with chronic LBP lasting for 12 weeks (7 female, 8 male) and fifteen older adults without LBP (6 female, 9 male) were included in the study. Patients complicated with prior low back surgery, sacroiliac arthritis, active malignancy, and neurologic disorders were excluded. Using the Spinal-Mouse we were able to evaluate spine range of motion and global curvature (Idiag, Volkerswill, Switzerland). This is an electronic computer-aided device that measures sagittal spinal range of motion and intersegmental angles non-invasively using a surface technique. The intra-class coefficients for curvature measurement with Spinal-Mouse are 0.92–0.95. To avoid inter-measure variation, all measurements were done by same physiotherapist. Each measurement was conducted three times and the mean value was obtained. Spine curvature, spine inclination (angle of the plumb line bisecting the trochanter major and running through the middle of the supporting area of the feet) and sacral inclination angle (Sac/ Hip: sacral slope defined as the angle between the horizontal and the sacral plate) were evaluated in the neutral upright position by sliding of the Spinal-Mouse along the spine. All spine data were calculated and displayed on the computer automatically. Thoracic kyphosis was expressed as a positive value and lumbar lordosis expressed as a negative value. This process was repeated with the subject in a maximum bending position and a maximum extension position allowing for measurement of spinal mobility. Balance was related to spine inclination and the entire spine alignment measured by the angle of the whole trunk. A large angle indicated worst balance.

Results: Mean age and BMI of patients were 68.15±2.15 years, 26.15±3.45 kg/m2. In standing position, thoracic kyphosis angle and whole trunk were significantly greater in non-LBP group. Additionally, angle of lumbar spine and angle of Sac/Hip were smaller in non-LBP group. The range of flexion (ROF) and the range of flexion-extension (ROFE) of non-LBP group were significantly wider than those in chronic LBP. The range of extension (ROE) showed no difference between the groups (Table 1).

Conclusion: We found that spinal mobility was significantly greater in non-LBP group. Further study in larger groups is needed to assess spinal mobility and its effect on LBP in older adults.

Keywords: Spinal mobility, elderly, physical therapy

Table 1. The differences in spinal flexibility between the groups

	Chronic LBP	Non-LBP
Thoracic Spine		
Standing	39.24 (4.22)	58.64(10.40)*
ROF	16.90 (10.54)	8.30(8.76)*
ROE	-5.10 (10.76)	-5.84(7.55)
ROFE	21.90 (13.42)	14.16(11.44)*
Lumbar Spine		
Standing	-22.58 (4.82)	-21.49(3.29)
ROF	42.54 (9.54	37.60(12.91)*
ROE	-5.62 (5.70)	-5.43(5.96)
ROFE	48.12(10.16)	41.02(15.44)*
Whole Trunk		
Standing	1.82(3.21)	6.10(6.71)*
ROF	89.88(19.17)	75.28(22.52)*
ROE	-18.20(6.34)	-16.56(5.82)
ROFE	108.00(21.93)	91.73(25.19)*
Sac/Hip		
Standing	11.32(5.20)	13.96(6.75)
ROF	49.96(17.68)	47.92(16.97)
ROE	-11.10(7.75)	-10.48(5.17)
ROFE	60.94(20.99)	59.35(17.42)

LBP: Low Back Pain; Standing: Angle in standing position; ROF: Range of Flexion; ROE: Range of Extension; ROFE: Range of Flexion and Extension. Whole trunk (Spinal Inclination): angle of the plumb line which bisects the trochanter major and runs through the middle of the supporting area of the feet. Sac/Hip: Sacral slope defined as the angle between the horizontal and the sacral plate. *p<0.05.

OP-04

THE EFFECT OF THE DRUG ADMINISTRATION AND EXERCISE ON SYMPTOMS AND HAPPINESS LEVEL IN YOUNGER ELDERLY

Seçil Gülhan Güner, Arzu Erden, Nesrin Nural

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Objective: The study was conducted to determine the effects of drug administration and exercise on symptoms and happiness level in younger elderly people who lives at home.

Materials and Methods: The study which was planned pre-test-post-test and intervention study was done by taking written permission from the institution and individuals. Elderly people were visited in their homes, their symptoms, happiness levels and well-being were determined. In addition, individual drug management training was given to person by nurse and individual exercise program was praticed by physiotherapist. It was requested that to continue the training and practises for 14 weeks thats were given to elderly person. After fourteen weeks, the symptoms, happiness levels and well-being of elderly people were determined again. Questionnaire Form, Drug Use Information Form, Edmonton Symptom Diagnostic Scale (ESDS), Short Form of Oxford Happiness Scale and Warwick-Edinburgh Mental Well-Being Scale were used to collect data. In the evaluation of the data SPSS 21.0 package program were used, the mean, frequency, percentage values and Paired Samples-T Test were used in the analysis of the data.

Findings: The average age of elderley people in the research is 69.22±3.37 years old. 71.4% of the elderly are obese, 54.3% are illiterate, 51.4% are not married, 68.6% have a core family structure and 42.9% live with their husbands. All of the elderly have chronic disease. Cardiovascular system diseases are the most common seen with %82.9. The proportion of the elderly who use 1-2 drugs per day is 51.4%. The most commonly used drugs were antihypertensives (80%) and analgesics (68.6%). 60% of the elderly are careful to be regular when using their medicines. There was a statistically significant difference ($p<.05$) between the 14-week medication administration and exercise program of the elderly and the 14th week ESDS and Oxford Happiness Scale Short Form average scores. However, there was no statistically significant difference between the 14-week old drug management and exercise program and the Warwick-Edinburgh Mental Well-Being Scale scores at the first and 14th weeks of life ($p>.05$).

Results: The results of our study showed that 14 weeks of individual drug administration and exercise program were effective in the symptoms which were due to their illness and happiness level in younger elderly. Drug trainings and exercise programs to be implemented in the elderly population so that it will help elderly people be more physically and psychologically healthy.

Keywords: Exercise, drug, hapiness, elder people

OP-05

EFFECTS OF AEROBIC EXERCISE IN AN OLDER ADULT WITH CHRONIC MAJOR DEPRESSIVE DISORDER WHO UNTREATED WITH PHARMACOTHERAPY

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Case Presentation: A 76 years old female patient admitted to our outpatient clinic with depressive symptoms which had been startedafter her daughter died unexpectedly. Before this time, she had no history of depression. After three months, she had applied to a psychiatrist andsertraline had been started for MDD. Subsequently, olanzapine had been added to reinforce the treatment. On admission, her depressive symptoms were present and she was referred to a geriatric outpatient clinic. She was evaluated by a geriatrician and diagnosed as chronic MDD.

Her physical examination was unremarkable. Her laboratory findings were within reference range. Her present medications were sertraline 50 mg twice daily, olanzapine 2.5 mg daily, and calcium 1500 mg plus vitamin D 880 IU daily. She followed-up with this treatment protocol for 6 months but no positive effects were seen in her depressive symptoms. Therefore, anti-depressant treatment was stopped. In the meantime, the case was consulted by a physiotherapist for improving her physical activity level.

This case were assessed with the following scales and evaluations to determine the her physical and mental status; Yesavagegeriatric depression scale (YGDS), Mini mental state examination (MMSE), knee extensor muscle strength with hand-held dynamometer, hand grip strength with Jamar hand dynamometer, Fall efficacy scale (FES), World Health Organization quality of life assessment for older adults (WHOQOL-OLD), Timed up and go test (TUG), Tinetti balance and gait test (TBGT) and Physical activity scale for elderly (PASE), respectively. The case was evaluated at baseline, 1 and 3 months post-treatment.

After medical evaluation, she was enrolled in a special exercise program. This program included 10 minutes warm-up, 20-25 minutes flexibility, balance and strengthening exercise, and 10 minutes cool-down exercise periods. Warm-up consisted of jogging, breathing, upper and lower extremity active exercises. The flexibility, strengthening and balance exercise sections included shoulder rolls, shoulder stretch,neck stretch, seated lifts, seated quadriceps stretch, ankle roll, shallow knee bends, toe rises, push-pulls, side stepping first to the right, then left, then backwards and finally in circles. Also, the cool-down period contained walking with slow speed, breathing and strecthing exercises. In the home program, patients performed exercise three times each week. This program was continued for 4 weeks.

In the post treatment evaluation, a dramatic improvement in depressive symptoms and physical status were observed (Table-1). Only, minor depressive symptoms were present over 3 months of follow-up.

Conclusion: Exercise therapy may be beneficial in the treatment of an elderly with MDD who untreated with pharmacotherapy. Further studies are needed to assess the effects of short-term and long-term exercise programs in older adults with MDD.

Keywords: Major Depressive Disorder, Physical Therapy, Elderly

Table 1. Effects of exercise on mood, physical and cognitive function

	Baseline	1 month follow-up	3 months follow-up
YGDS (0-15)	10	5	3
MMSE score (0-30)	28	28	29
Knee extensor muscle strength (kg)	7.5	7.5	8.2
Hand grip strength(kg)	4.6	4.6	4.8
FES (10-100)	55	54	50
WHOQOL-OLD	76	76	92
TUG (second)	9.81	9.51	8.42
TBGT score (0-28)	22	25	28
PASE (0-361)	46.27	50.21	62.15

YGDS; Yesavage Geriatric Depression Scale, MMSE; Mini Mental State Examination, FES; Falls Efficacy Scale, TUG; Timed Up and Go Test, TBGT; Tinetti Balance and Gait Test, PASE; Physical Activity Scale For Elderly.

Higher scores of YGDS show greater depressive mood.
Higher scores of MMSE show better cognitive performance.
Higher scores of knee and hand strength show better muscle strength.
Higher scores of FES indicate that increasing in fear of falling.
Higher scores of WHOQOL-OLD show better quality of life.
Higher scores of TUG show reduction in dynamic balance and gait performance.
Higher scores of TBGT indicate that reduction in risk of falls.
Higher scores of PASE show improving physical activity level.

OP-06

LET'S DIAGNOSE SARCOPENIA WITH A DEEP BREATH

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Introduction: Sarcopenia, loss of skeletal muscle mass accompanied by at least one of loss of muscle strength or function, is also related with a decline in the function of the respiratory muscles. Although, some of the preclinical studies designed in mice have shown sarcopenic animals may have thinner diaphragmatic muscle than non-sarcopenic ones, no clinical studies are available investigating diaphragm thickness in sarcopenic patients. The aim of this study is to show whether the sarcopenic patients have thinner diaphragm muscle compared to control or not.

Material and methods: Thirty sarcopenic and 30 non-sarcopenic elderly patients aged over 65 were included in the study. All patients underwent comprehensive geriatric assessment. The patients known having any type of pulmonary disorders such as asthma and chronic obstructive pulmonary disease were excluded from the study. Diagnosis of sarcopenia was done according to the criteria of the European Working Group on Sarcopenia in Older People. Ultra-sonographic evaluations of the patients were carried out by experienced radiologists. Diaphragm thickness was measured in the position of end of deep inspiration, neutral and end of expiration. Also, peak expiratory flow (PEF) of the patients was evaluated by a peak flow meter.

Results: The mean age of the patients was 76.7±6.4 years and 56.7% were female. Gender rate was similar between sarcopenic and non-sarcopenic groups (p=0.602). Diaphragmatic thicknesses in three different positions (deep inspiration [2.35 mm (min-max: 1.30-4.10) vs. 2.50 mm (min-max: 1.90-4.90)], neutral [1.80 mm

(min-max: 1.00-2.80) vs. 2.00 mm (min-max: 1.30-3.90)] and end of expiration [1.15 mm (min-max: 0.70-2.50) vs. 1.55 mm (min-max: 0.50-3.40)]) were found to be thinner in sarcopenic patients compared to non-sarcopenic group (p=0.023, p=0.017, p=0.003, respectively). Also, PEF results were lower in sarcopenic patients than non-sarcopenic group (245 L/min [min-max: 150-500] vs. 310 L/min [min-max: 220-610], p=0.001).

Conclusion: This study demonstrated that sarcopenia may be associated with lower diaphragmatic thickness and PEF results.

Keywords: Sarcopenia, diaphragmatic muscle thickness, PEF

OP-07

ASSOCIATION OF PHYSICAL FRAILTY WITH COGNITIVE FUNCTION AND MOOD IN PATIENTS WITHOUT DEMENTIA AND DEPRESSION

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Aim & Background : Frailtyis mostly defined as a geriatric syndrome consists of medical problems and functional loss increasing the risk of hospitalization and may result in mortality.It is thought that physical frailty is related to cognitive functions and social status. In this study, we evaluated the associationof physical frailty with cognitive function and mood in patients without dementia and depression.

Material and Methods: In this study, we evaluated 612 patients aged 65 years and over admitted to our outpatient clinic. For evaluation of physical frailty we used Fried criteria. According to Fried criteria, the patients having 3 or more points were reported as frail, having 1 or 2 points as pre-frail and 0 point as robust. We also performed detailed comprehensive geriatric assessment. Depression status of the patients was screened with Yesavage Geriatric Depression scale. Cognitive functions were screened with MMSE and clock drawing test. Patients with dementia and depression were excluded.

Results: Mean age of the patients was 72 and 58% was female. Diabetes mellitus and hypertention were the most common comoridities (35,6% and 67,2% respectively). Forty five percent of patients were robust, 48.4% were prefrail and 6.5% were frail. When grouped according to frailty, clock drawing test (p<0.001), MiniMental State Examination test (p<0.001), Yesavage Geriatric Depression scale(p:0.01) weresignificantly different between groups.Age (p: 0.009), educational level, being university graduate(p:0.031),three words recall test(p: 0.014), Activities of Daily Livingscore (p: 0,006), Instrumental Activities of Daily Livingscore (p<0.001),Mini Nutritional Assessment (p: 0.001) were determined to be independent factors related to frailty.

Conclusion: In this study, we have demonstrated that cognitive function and mood are associated with physical frailty in patients without dementia and depression. Further studies are needed to elucidate the causal relationship between these entities.

Keywords: frailty, geriatrics, mood, cognitive frailty,

OP-08

SHORT-TERM MORTALITY RATES AND RELATED FACTORS FOLLOWING PERCUTANEOUS ENDOSCOPIC GASTROTOMY

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Introduction: In situations where oral feeding is not possible, nutrition is first provided through the nasogastric route, and later via percutaneous endoscopic gastrotomy (PEG). Although PEG is generally a safe procedure, it may result in morbidity and mortality. The aim of our study was to determine the short-term mortality rates after PEG and factors influencing these rates.

Methods: We included all patients who underwent PEG between January 1, 2010 and December 31, 2016. Data were collected by retrospective. Patients with mortality within a 30-day follow-up period and those without were compared.

Results: A total of 120 patients were evaluated in the study. The mean age was 67.22±18.19 years and 70 of the patients were male. The most common indication for PEG was cerebrovascular disease with 69 patients (57.5%) (Table 1).

Thirty-four patients (28.3%) died within 30 days of undergoing PEG; 64.4% of those patients were in the intensive care unit. Comparison of comorbid diseases in patients deceased and surviving after 30 days revealed that the presence of coronary artery disease (CAD) significantly increased mortality. Evaluation of biochemical markers in the same groups showed that high C-reactive protein (CRP) levels and low albumin levels were associated with mortality. In terms of days of hospitalization before undergoing PEG, patients who underwent PEG earlier had significantly higher mortality rates (Table 2) Cox regression analysis included variables which emerged as significant in Kaplan-Meier analysis: CRP, albumin, hemoglobin, leukocyte count, and coronary artery disease. CRP values ≥ 78.31 increased mortality 8.756 fold, and albumin levels < 2.71 increased mortality by 2.255 fold.

Patients with CRP values under 78.3 mg/L had a mean survival of 28.6 days, while patients with CRP values over 78.3 mg/L had a mean survival of 20.2 days. Patients with albumin levels under 2.71 mg/dL had mean survival of 21.3 days (min 18.2 - max 24.5 days), whereas patients with albumin levels over 2.71 mg/dL had a mean survival of 27.1 days (min 25.5 - max 28.7 days).

Discussion: In this study, we determined the 30-day mortality rate after PEG to be 28.3%. CRP and albumin levels were identified as independent risk factors for mortality. Cut-off points in our study were 78.3 mg/L for CRP and 2.71 mg/dL for albumin. We determined a higher cut-off value for CRP than that reported in previous studies, which may be due to the inclusion in our study of patients in intensive care, patients on mechanical ventilators, and patients at high risk of infection.

Furthermore, PEG is not an emergent procedure, and should be performed at the appropriate time when conditions are favorable. A cautious approach is warranted in the presence of inflammation and/or infection.

Keywords: percutaneous endoscopic gastrotomy, mortality

Table 1. Characteristics of patients who underwent PEG

n (%)
Age (years)
<65 42 (35%)
≥65 78 (65.0%)
Indication for PEG
Cerebrovascular disease 69 (57.5%)
Neurologic disease 25 (20.8%)
Dementia 16 (13.3%)
Malignancy 10 (8.3%)
Department implenting PEG
Intensive care unit 43 (35.8)
Inpatient units 77 (64.2%)

Table 2. Thirty-day mortality and associated risk factors

	Deceased (n=34)	*Surviving (n=86)*	*P value*
Comorbid conditions			
Diabetes mellitus	2 (5.9%)	8 (9.3%)	>0.05
Coronary artery disease	11 (32.4%)	12 (14.0%)	0.021
Cerebrovascular disease	21 (61.8%)	57 (66.3%)	>0.05
Dementia	6 (17.6%)	18 (20.9%)	>0.05
Malignancy	-	9 (10.5%)	>0.05
Hypertension	11 (32.4%)	27 (31.4%)	>0.05
Chronic kidney disease	2 (5.9%)	2 (2.3%)	>0.05
Bioindicators			
CRP (mg/L)	124.5 (19.2-737.0)	28.6 (1.5-284.0)	< 0.001
Albumin (g/dL)	2.67 (0.3-4.2)	2.97 (1.67-4.56)	0.001
Hemoglobin (g/dL)	11.6 (7.3-18.2)	9.9 (8.0-15.7)	0.002
Thrombocyte count	286150	282500	0.060
Leukocyte count	9258	13240	0.002
Inr	1.14	1.09	0.193
Creatinine (mg/dL)	0.6	0.6	0.470
Days of Hospitalization Prior to PEG	13 (1-170)	34 (2-89)	<0.001

OP-09

EVALUATION OF OXIDATIVE STRESS AND ANTIOXIDANT STATUS IN PLASMA AND ERYTHROCYTES IN OLDER DIABETICS WITH SARCOPENIA

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Introduction: Sarcopenia is a syndrome characterized by decreased muscle strength, mass and function. It is thought that diabetes is associated with increased oxidative stress; oxidative stress and reactive metabolites also play a role in the etiopathogenesis of sarcopenia. In this study, it is aimed to evaluate oxidative stress and antioxidant parameters in diabetics in geriatric age group and to evaluate its relation with sarcopenia.

Material and Method: Within the scope of the study, diabetic patients over 65 years were evaluated according to EWGSOP criteria and sarcopenic ones included case group. Non-sarcopenic diabetic patients with similar age and gender characteristics were included in the study as control group. A total of 60 elderly patients were enrolled in the study, including 30 case groups and 30 control groups. Comprehensive geriatric assessments, anthropometric measurements, walking speed and hand strength measurement with dynamometer were performed on the subjects included in the study. Muscle mass was assessed by bioimpedance. Plasma malondialdehyde (MDA), glutathione peroxidase (GSH-Px) and erythrocyte MDA, GSH-Px, superoxide dismutase (SOD), catalase, xanthine oxidase (XO) measurements were performed in laboratory values in addition to routine laboratory tests.

Results: There was a statistically significant difference in the number of medications, presence of dementia and cardiovascular disease among the case and control groups. Functional dependence in daily activities was higher in sarcopenic group and sarcopenic patients had lower values in anthropometric measurements. Bioimpedance analysis revealed that the phase angle was significantly lower in the sarcopenic group. While no significant difference was found between the two groups in the routine laboratory examinations, serum ESH and CRP levels were significantly higher in the sarcopenic group. Plasma XO activity, which is one of the oxidative stress parameters, was significantly higher and plasma GSH-Px level, which is one of the antioxidant parameters, was significantly lower in the sarcopenic group. There were no significant differences between the two groups in the other oxidative stress and antioxidant parameters examined in the study.

Discussion and Conclusion: The identification of the sarcopenia in the diabetic population and the identification of related factors will have important consequences in follow-up and treatment. In this study, dementia and low BMI in diabetic ages are independent risk factors for sarcopenia. In addition, low values of phase angle, ESR and CRP elevation, high plasma XO activity and low plasma GSH-Px levels were found to be associated with sarcopenia. There is a need for more studies to investigate the relationship between oxidative stress and antioxidant status and sarcopenia, which may also shed light on sarcopenia treatment.

Keywords: Sarcopenia, diabetes mellitus, oxidative stress, antioxidants

Table1. Descriptive and clinical characteristics in case and control groups.

	Case (n=30)	*Control (n=30)*	*P*
Age (year), ±SD	79,60±5,95	77,07±5,85	0,102a
Gender, n (%)			
Female	19 (63,3)	19 (63,3)	1,000
Male	11 (36,7)	11 (36,7)	1.000
Education level, n (%)			
Uneducated	12 (40,0)	13 (43,3)	0,793
Educated	18 (60,0)	17 (56,7)	0,793
Comorbid diseases, n (%) 28 (93,3)	28 (93,3)	28 (93,3)	1,000
Hipertension	22 (73,3)	24 (80,0)	0,542
Cardiovascular disease	17 (56,7)	8 (26,7)	0,018
Hyperlipidemia	13 (43,3)	9 (30,0)	0,284
Osteoporosis	12 (40,0)	9 (30,0)	0,417
Depresion	4 (13,3)	3 (10,0)	1,000
Demantia	10 (33,3)	1 (3,3)	0,003
Diabetes duration (year), median (min-max	10 (2-35)	11 (2-45)	0,789c
Drug use, median (min-max)	6,5 (1-13)	4,5 (2-11)	0,028c
History of fall (last 1 year), n (%)	12 (40,0)	10 (33,3)	0,592

Table 2. Comparison of case versus control groups in terms of oxidative and antioxidative status.

	Case (n=30)	*Control (n=30)*	*p**
Plasma MDA#, median (min-max)	9,52 (0,56-29,68)	9,96 (1,21-30,81)	0,515
Plasma GSH-Px, median (min-max)	0,154 (0,101-0,274)	0,204 (0,120-0,312)	0,003
Erythrocyte catalase, ±SD	44139,6±9576,3	48812,2±10021,7	0,070a
Erythrocyte GSH-Px (%), ±SD	12,67±2,03	13,48±1,48	0,083a
Plazma XO, medyan (min-max)	0,406 (0,225-0,775)	0,312 (0,112-0,712)	0,006
Eritrosit MDA, ±SD	906,10±330,58	950,60±293,06	0,583a
Eritrosit SOD, ±SD ,3043a	256,78±120,70	287,07±124,92	,3043a

: Mean; **SD:** Standart deviation; **a:** Student's T Test;**n:** patients numbers; **MDA:** Malondilaldehyde; **GSH-Px:** Glutation peroxsidase; **XO:** Xsantin oxidase; **SOD:** Superoxide dismutase *Mann-Whitney U Testi

OP-10

WHICH FRAILTY SCALE IS BEST TO PREDICT 3-YEAR MORTALITY IN COMMUNITY-DWELLING TURKISH ELDERLY?

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Aim: To determine if there is an association between frailty and 3-year mortality in the community-dwelling Turkish elderly.

Methods: The Fried Frailty Index (FFI) and FRAIL scales data from the Kayseri Elderly Health Study (KEHES) were used. KEHES was a cross sectional study in which 1% of community dwelling elderly (89,303) was included in. Recruitment of community dwelling elderly was done in August-December 2013 period from 21 Family Health Centers. The community-dwelling elderly (n=907) who were included in the frailty prevalence study were checked again in 2016 for 3-year frequency of mortality. From the list of deaths which was obtained from the local health authority (Türk Halk Sağlığı Kurumu/ Kayseri) during the previous three years this cross match for the current study was done. Uni- and multivariate analyses were conducted to determine the association between frailty and mortality as assessed by FRAIL, FFI.

Results: The frequency of three-year mortality was 3.9% (n=35/907). The gender specific mortality was 4.7% (n=21) and 3.1% (n=14) in males and females, repectively. The mortality frequency in the elderly ≥75 years of age was 7.2% (n=19) and 2.5% (n=16) in the 60-74 age group. The mortality frequency in frail, pre-frail, and non-frail elderly was 54.8%, 35.5%, and 9.7%, respectively for the FFI scale. The corresponding mortality frequencies for the FRAIL scale were 26.5%, 52.9%, and 20.6 %, respectively.

In univariate logistic regression analysis independent from age and gender, both the FFI and FRAIL scale were associated with significantly increased mortality (OR 16.9, 95%CI 2.2-125.1 and OR 3.1 95%CI 1.3-7.4 respectively). In age specific analysis only the FFI was associated with significantly increased mortality in the 60-74 year old elderly. In age and gender specific analysis both the FFI and FRAIL scale were associated with significantly increased mortality in the 60-74 year old male elderly (OR 9.4 95% CI 1.1-74.6, and OR 4.3 95% CI 1.1-16.7, for FFI and FRAIL respectively). In multivariate analysis only the FFI was significantly associated with increased mortality (OR 14.2, 95%CI 1.8-107.6).

Conclusion: Both the FFI and FRAIL scale may be significant predictors of 3-year mortality in the sample which is not adjusted for age and gender. However, the FFI may be considered as the strongest predictor for 3-year mortality in primarily male gender less than 75 years of age.

Keywords: Frailty, Mortality, Elderly, Community-dwelling

OP-11

VALIDATION AND RELIABILITY OF THE TURKISH VERSION OF SUBJECTIVE GLOBAL ASSESSMENT TEST IN HOSPITALIZED OLDER PEOPLE

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Objective: Malnutrition is a state resulting from lack of intake or uptake of nutrition that leads to altered body composition or body cell mass. Although there are numerous screening test, most of them were not validated in our country. In this study, the validity and reliability of the Turkish version of the Subjective Global Assessment (SGA) test used to assess malnutrition in hospitalized older people was evaluated.

Methods: A total of 98 patients 56 women (57.1%) and 42 men (42.9%) with an average age of 73.3 ± 6.6 were included in the study. 50 (51%) and 48 (49%) of the patients were followed at the medical and surgical wards, respectively. Two geriatrician experienced in the field of malnutrition who were unaware of the SGA results, interpreted the patients nutritional status after the evaluation of several parameters such as medical history including weight loss, appetite, disease severity, neuropsychological problems, mobility problems, dependency in activities of daily living, anthropometric measurements, biochemical markers, bioimpedance analysis, hand grip strength, geriatric assessment and 3-day dietary records. Based on these, the patients were divided into "at nutritional risk" and "not at nutritional risk" groups by specialists. Concordance between the two clinicians' clinical assessment was analyzed by kappa statistics and excellent concordance was found (kappa=0.861), therefore more experienced specialist's decisions was accepted as gold-standard. A third physician performed SGA within 48 h of admission. At the end of the SGA evaluation patients with a category A were classified as ''non-malnourished'' and those with categories B and C were classified as ''malnourished''.

Results: In general, SGA was found to be 91% both sensitive and specific compared to the clinician's assessment of malnutrition. The positive predictive value and the negative predictive value were 89% and 91%, respectively.

Conclusion: The Turkish version of the SGA test in hospitalized older people is a valid and reliable method for evaluating malnutrition.

Keywords: Malnutrition, Subjective Global Assessment, Older People, Hospitalized

OP-12

VALIDATION OF THE MALNUTRITION UNIVERSAL SCREENING TOOL (MUST) FOR THE MALNUTRITION IN TURKISH ELDERLY HOSPITAL SETTINGS

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Introduction: A variety of screening tools are used for the determination of malnutrition, one of the most one is the Malnutrition Universal Screening Tool (MUST). In this study, we have investigated the validation of the MUST test in Turkish elderly hospital settings.

Material and Methods: A total of 112 inpatients hospitalized in medical or surgical wards were included for the study. All the patients underwent comprehensive geriatric assessment. Nutritional status of the patients was evaluated by two geriatricians. There was very good agreement between these clinicians (kappa=0.85). The patients were also evaluated by using MUST test for nutritional status by a different clinician blinded to the decisions of the geriatricians for the nutritional status of the patients. Nutritional status of the patients according to the MUST and the geriatrician decision was compared with Cohen's kappa analysis. Also, the sensitivity and specificity results of the MUST test for the malnutrition were evaluated.

Results: The mean age of the patients was 73.1±6.4 years and 56% of them were female. The numbers of the patients in medical and surgical wards were 55 and 57, respectively. There was good agreement between the results of MUST test and geriatrician decision for the assessment of nutritional status of the patients (kappa = 0.66). The sensitivity, specificity, positive predictive and negative predictive values of the MUST test for detecting malnutrition in elderly hospital settings were 69%, 95%, 92% and 80%, respectively.

Conclusion: This study showed that the Turkish version of the MUST test is validated for geriatric inpatients.

Keywords: MUST, Validation, Malnutrition

OP-13

THE FREQUENCY AND CAUSES OF NEPHROTIC SYNDROME IN HOSPITALIZED PATIENTS OVER 65 YEARS OF AGE

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Objective: Nephrotic syndrome (NS) in the elderly is often caused by primary kidney diseases. The most common secondary cause is diabetes mellitus (DM). We aimed to determine the frequency of nephrotic syndrome, primary and secondary causes of NS in hospitalized patients aged 65 years and older in our study.

Material and methods: Between October 2000 and October 2014, patients aged ≥65 years who were hospitalized in the Internal Medicine Clinic, were scanned with the NS diagnostic code and reached a file of 92 patients. When the files were examined, 31 patients were diagnosed with NS. Biochemical parameters and pathology results were examined retrospectively. IBM SPSS 20 package program was used for statistical analysis.

Results: In 9 of the patients, biopsy was not performed because of general risk factors, atrophic kidney, bleeding diathesis, etc. Thirty-one patients ≥65 years of age were included in the study where 32.3% of the patients were female and 67.7% were male. The mean age was 72.6 ± 5.2 (65-87) years. 58% of the patients had hypertension, 26% had DM, 23% had coronary artery disease, 58% had hyperlipidemia, and 13% had connective tissue disease. The mean serum creatinine concentration was 2.43 ± 1.82 mg/dl, the mean creatinine clearance was 42.54 ± 29.00 ml/min /1.73 m2, the mean the protein level in 24 hour urine was 6.23±3.64 gr, the mean protein level was 5.66 ± 2.41 gr, the mean serum albumin level was 2.77 ± 0.88 g/dl and the mean Hb level was 11.41 ± 2.12 g/dl, the mean total cholesterol level was 260.75 ± 107.10 mg/dl, the mean trglyceride level 233.29±120.69 mg/dl. Of the 31 patients, in 22 patients (8 female, 14 male) biopsy results were reached where 40% had Membranous Glomerulonephritis (MGN), 25% had amyloidosis, 10% had MPGN, 10% had FSGS and 15% DM.

Conclusions: MGN was the most common cause of NS in our study in accordance with the literature in the elderly. The second cause of NS which is Minimal Lesion Disease, was not detected. We found that amyloidosis was in the second place. We are planning to increase our data by scanning the previous years. In addition, this study aims to emphasize the necessity of renal biopsy in the presence of nephrotic syndrome in the elderly.

Keywords: nephrotic syndrome, hospitalized patients, elderly

OP-14

SLEEP QUALITY AND RELATED FACTORS IN THE ELDERLY

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Background and Aim: With increasing age, sleep quality declines and cognitive functions deteriorate. About half of the elderly complain of poor sleep quality. Poor sleep quality reduces quality of life, leads to emotional disturbances such as anxiety and depression, is a cause of polypharmacy, and increases frailty and mortality. Furthermore, the deterioration in cognitive functions that frequently accompanies aging can also cause sleep disturbances.The aim of this study was to investigate sleep quality and related factors in elderly Turkish individuals.

Materials and Methods: The study included patients aged 65 years and older who presented to the geriatric outpatient clinic of our hospital between June 1 and September 1, 2016.Cognitive functions were assessed using the Mini Mental (MM) test. The short Beck depression scale was used to evaluate the presence of major depression. Sleep quality was assessed using the Pittsburgh Sleep Quality Index (PSQI); daytime sleepiness was evaluated using Epworth Sleepiness Scale (≥10); and risk of obstructive sleep apnea syndrome (OSAS) was assessed with the Berlin Questionnaire.

Results: A total of 212 geriatric patients with a mean age of 74.58±7.43 were included. Sleep quality was reported as poor by

34.9% of the subjects, 14.2% reported excessive daytime sleepiness, and 85.8% were found to be at risk for OSAS. PSQI score indicated good sleep quality in 138 (65.1%) of the subjects and poor sleep quality in 74 (34.9%) of the subjects. Patients with chronic lung disease, major depression, and gonarthrosis had the poorest sleep quality (p=0.023, p<0.001, p=0.041, respectively).

Patients with chronic lung disease reported significantly more daytime sleepiness compared to those without (25.6% vs 11.6%, p=0.023). Sleep quality was significantly poorer in patients diagnosed with major depression when compared with subjects without depression (100% vs 31.7%, p<0.001). Patients with gonarthrosis also had significantly poorer sleep quality compared to those without (54.5% vs 32.6%, p<0.041).

Sleep quality was 2.24 times worse in individuals with normal cognitive functions compared to those with cognitive deterioration; and 3.99 times worse in subjects with depression compared to those without. Subjects with cognitive deterioration were found to have better sleep quality than those without (71.3% vs 57.7%, p=0.039).

Conclusion: In our study, we demonstrated chronic lung disease was associated with more daytime sleepiness. We found that subjects with major depression, gonarthrosis, and chronic lung disease had poorer sleep quality. However, in contrast to the literature, subjects with deterioration of cognitive functions appeared to have better sleep quality than those with intact cognitive functions. In accordance with the literature, subjects with depression reported requiring longer to fall asleep.

Keywords: sleep quality,elderly, daytime sleepiness,obstructive sleep apnea syndrome

OP-15

COMPREHENSIVE EVALUATION OF BONE MARROW BIOPSY RESULTS IN OUR GERIATRIC CLINIC: DIAGNOSIS, PRESENTATION AND MORTALITY

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Introduction: With aging, the frequency of hematologic diseases is increasing. Bone marrow biopsy (BMB) is a procedure that allows diagnosis of many diseases affecting bone marrow. The anamnesis, physical examination and laboratory findings of the patient are taken into account when making BMB decison. Bone marrow pathologies in the elderly affect life quality as much as the lifespan. We aimed to determine the most common hematologic pathologies and presentations in our patient group and to investigate their functional and mortality effects in our study

Method: Patients who underwent BMB between years of 2006-2016 were enrolled in Geriatrics Department. The patients studied were not known any haematologic disease or were followed. BMB pathology was found in files and 153 patients were found to be significant. Patient demographics and comprehensive geriatric assessment test scores were recorded. In order to determine the life situations of the patients; a search was made through the Ministry of Health, the Turkish Public Health Agency Death Notification System.

Results: The demographics and complaints of patients are summarized in Table 1. The preliminary diagnosis of biopsies and results are shown in Table 2. Classified as 'other'; Patients treated as hemodynamic changes secondary to immunosuppressive use, pancytopenia caused by methimazole, anemia and thrombocytopenia due to apixaban use. Patients' biopsy indications and biopsy results comparison are shown in Table 3. Bone marrow malignancy was detected in 42.5% of the patients. When malignancy-life status results were evaluated, it was determined that 40% of the patients were alive. It was determined that 24.6% of the patients died longer than 12 months.Comparison of life span and goodness status; Patients with poor walking speed have a significantly shorter lifetime.Lawton-Brody, Katz and handgrip scores were found to be unrelated. It is seen that survival time of patients with poor walking speed is significantly shorter in malignancy.

Discussion: Studies on BMB results in the elderly are few in the literature. In a study conducted by Manion et al, BMB in patients over 85 years of age, cytotopenia was first reported in 36.1% .In our study, the most common cause of biopsy indications is anemia with 51%. It is important to note that if anemia has not been diagnosed as a nutritional cause, bone marrow should be followed even if the end result is normal. It is important to keep in mind the possibility of becoming MDS in the follow-up. In our study, an asymptomatic patient group (7.8%) and 8.5% patient group with no problems in laboratory values warn us against atypical presentations and importance of detailed anamnesis-physical examination. The presence of a disease group that will benefit from treatment and prolonged life expectancy in the elderly increases importance of BMB. After comprehensive geriatric evaluation, BMB should be performe in elderly foreseen to receive treatment.

Keywords: Bone marrow biopsy, elderly, comprehensive geriatric assessment for functionality, life span

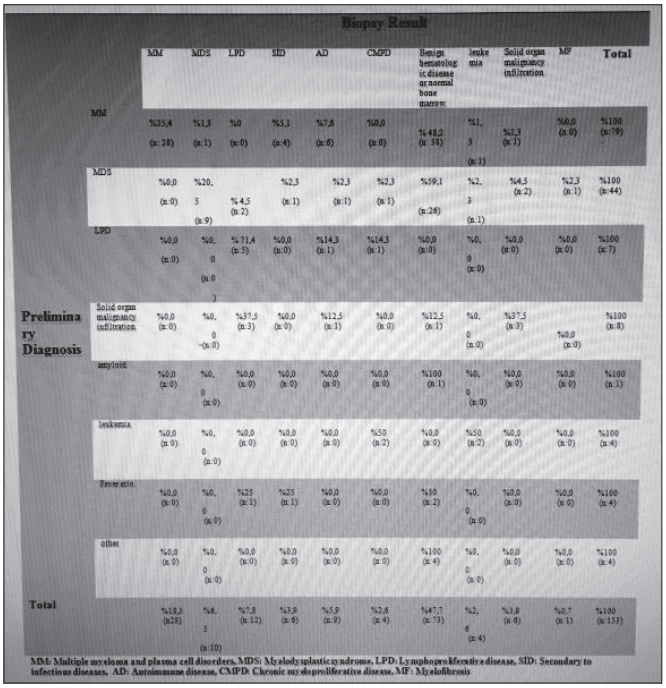

Figure 1.

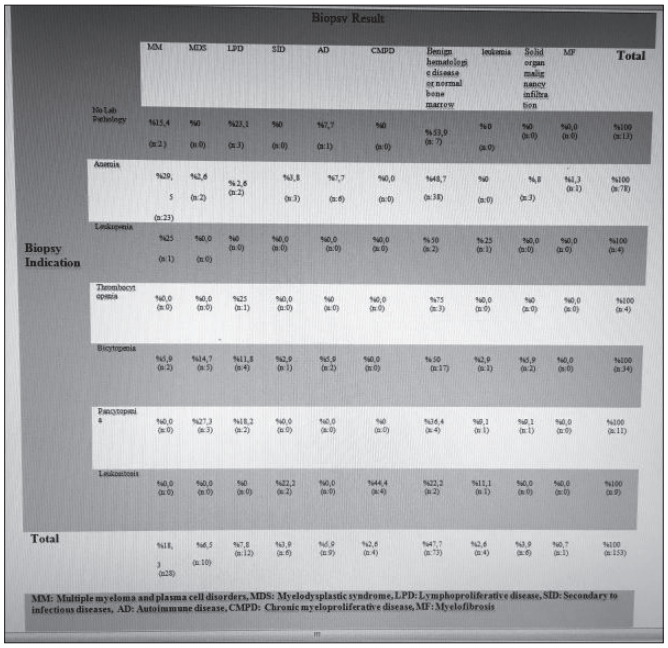

Figure 2.

Table 1. Demographic Information and Complaints of Patients

Average age	*77.2 ±6.931*
Female	%57.5
Male	%42.5
Median number of drugs	4
Polypharmcy (≥ 5 Drugs)	%47.7
Diseases	
Diabetes Mellitus	%39.9
Hypertension	% 84.3
Chronic Obstructive Pulmonary Disease	%22.9
Thyroid Diseases	%14.4
Chronic renal failure	%22.2
Benign Prostate Hypertrophy	%17
Cerebrovascular Event	%11.8
Atrial Fibrillation	%13.7
Atherosclerotic Heart Disease	%39.9
Osteoporosis	%20.3
Autoimmune Diseases	%11.8
Dementia	% 8.5
Parkinson	%4.6
Complaints	
Asymptomatic	%7.8
Bleeding Disorder	%12.4
Fatigue and loss of appetite	%64.7
Weight Loss	%37.9
Sweating	%7
Abdominal Pain	%13,1
Waist And Extremity Pain	%37.3
Itching	% 5.2
Fever	% 15

OP-16

ASSESSMENT OF RISK FACTORS FOR BRONCHOSCOPIC COMPLICATIONS IN PATIENTS SEVENTY FIVE YEARS OLD AND ABOVE

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Background: Flexible bronchoscopy is a procedure that is commonly used for diagnostic and therapeutic purposes in pulmonary diseases. It can be easily tolerated by the patient and complication rates are reported to be low. It is reported that the need for flexible bronchoscopy is increasing in elderly poulation recently. Although studies have shown that there is no major effect on procedural-related complications by age alone, the risk factors for complications in older elderly groups are not clearly defined.

Aim: To describe the rates of bronchoscopic complications and risk factors in 75 years old and above elderly patient group.

Method: The study was performed retrospectively and the data of 1683 patients who underwent bronchoscopy between May 2009 and December 2016 were screened in our Department of Pulmonology.

240 patients who were 75 years old and above from 268 patient files were included in the study. For the assessment of complications, 243 patients under the age of 75 years who underwent the same procedure were randomly selected. Age, gender body mass index (BMI), came from nursing home, need of individual care, dementia, cerebrovascular event, mobility, decubitus ulcer , percutaneous endoscopic gastrostomy (PEG), hypoalbuminemia, anemia, Diabetes mellitus (DM), chronic renal failure (CRF), chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), history of malignancy , trauma history, fracture history, polypharmacy, amount of used midazolam for procedure were evaluated.

Results: When the demographic data of patients over 75 years of age were examined, 167 patients were male, mean age was 79 ± 3.8 years and mean BMI was 25.6 ± 4.5 (Table 1). When the indications for treatment were considered in this group of patients, malignancy was 46.9%, infection was 38% and other causes were 14.6%. The mean midazolam dose was 1,5 ± 1,3 mg. According to complication results, 9/240 had complication, pneumothorax in 1 case, bleeding in 1 case, desaturation in 7 cases without mortality. The mean age in complicated group was 79.1 years and 78.9 years in those who did not complicated (p> 0.005). The cases below the age of 75 years, complication developed in 3/243 cases (1pneumothorax, 1 hemorrhage, 1 desaturation). The mean midazolam dose used was found to be 3.8 ± 1.3 mg (p> 0.05), but no significant difference was found between the two groups in terms of risk of developing complications (p> 0.05). There was no significant difference for the complication rate and type of the procedure between two groups.The presence of anemia, presence of PEG, and immobility were defined as risk factors for complication development in older age group (Table 2).

Result: In the elderly group, bronchoscopy is a safe procedure regardless of the type of procedure and age. Anemia, immobilization and presence of PEG can be considere as risk factors in this group. These patients should be closely monitored due to the risk of possible complications.

Keywords: Bronchoscopy Compication Elderly Invasive procedure 75 years old

Table I: Demographics of patients

		< 75 years (n=243)	75 years and above (n=240)
Gender(n)	Male	141	167
Age (mean±SD)		44,7±13,7	79±3,8
Indication (%)	Malignancy	69 (%28,4)	113 (% 46,9)
	Infection	114 (%46,9)	92 (% 38,5)
	Others	60 (%24,7)	35 (% 14,6)
Type of procedure (%)	BAL+Brush	143 (%58,8)	149 (% 61,9)
	BAL+Brush+Biopsy	100 (%41,2)	91 (% 38,1)
Place of Procedure perfomed (%)	Bronchoscopy Unit	238 (%97,9)	225 (% 93,7)
	Intensive Care	5 (%2,1)	15 (% 6,3)
Midazolam (mean±SD), mg		3,8±1,3	1,5±1,3
BMI (mean±SD), kg/m²		N/A	25,6±4,5
Komorbiditeler (%)	COPD	N/A	95 (% 39,6)
	CAD	N/A	75 (% 31,3)
	CHF	N/A	43 (% 17,9)
	CRF	N/A	33 (% 13,8)
	HT	N/A	108 (% 45)
	DM	N/A	73 (% 30,4)
	Malignancy	N/A	40 (% 16,7)
Dementia (%)		N/A	29 (% 12,1)
Immobility (%)		N/A	29 (% 12,1)

Table II: Comparison of complications according to clinical parameters in patients 75 years old and above

Parameter	Complication		p value
	No (%)	Yes (%)	
Nursing Home	14 (100)	0 (0)	> 0,05
Loss of Functions	76 (95)	4 (5)	> 0,05
Dementia	25 (96,2)	1 (3,8)	> 0,05
Cerebrovascular Event	22 (91,7)	2 (8,3)	> 0,05
Anemia	35 (89,7)	4 (10,3)	**0,027***
Hypoalbumemia	39 (97,5)	1 (2,5)	> 0,05
Decubitus Ulcers	8 (80)	2 (20)	> 0,05
İmmobility	21 (80,8)	5 (19,2)	**0,001***
PEG	6 (75)	2 (25)	**0,036***
Malignancy	33 (94,3)	2 (5,7)	> 0,05
History of Trauma	40 (95,2)	2 (4,8)	> 0,05
History of Fractures	14 (93,3)	1 (6,7)	> 0,05
Polipharmacy	112 (95,3)	6 (4,7)	> 0,05

OP-17

NUTRITIONAL STATUS AND SARCOPENIA IN PATIENTS WITH INFLAMMATORY BOWEL DISEASE OVER FIFTY YEARS OF AGE

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Objective: Malnutrition is a major complication of inflammatory bowel disease (IBD). Malnutrition leads to loss of lean mass and sarcopenia, which are with increased risks for poor quality of life and physical disability. Those risks are higher in the elderly. There are very few studies on sarcopenia and IBD in the literature. So we aimed to assess sarcopenia and the nutritional status of IBD patients over 50 years of age.

Methods: A total of 111 patients over 50 years of age from outpatient clinic of Gastroentereology Department- IBD section were included in the study between January 2016 and January 2017. Antrohropometric measurements, dietary and mobility histories were taken. Gait speed, hand grip strength, bioelectrical impedance analysis and Mini nutritional assessment were performed for each patient. Sarcopenia was diagnosed with the EWGSOP criteria.

Results: Presarcopenia rates according to fat free mass index (FFMI) and calf circumferences (CC) with the two cut-offs 31 and 33 were 5.4%, 2.4%, and 9.9%, respectively. Sarcopenia and severe sarcopenia rates were 8.1% and 2.7% according to CC, and 4.5% and 1.8% according to FFMI. Sarcopenia and malnutrition frequencies, related factors , and relationship between the parameters will be discussed.

Conclusion: According to our knowledge, this is the first study to assess sarcopenia based on body composition, muscle strength and physical performance. Malnutrition and sarcopenia are substantial issues in IBD patients, further studies evaluating the impact of medications (corticosteroids, etc) and activity of the disease on outcomes, morbidity and mortality of IBD patients are needed.

Keywords: Nutritional status, sarkopenia, inflammatory bowel disease, advanced age

Table 1. Characteristics of the patients with inflammatory bowel disease

Characteristics	*Total (n = 111)*
Agea (years)	61.2 ± 6.7 (51- 83)
Patients ≥ 60 years of age, n (%)	58 (52.3)
Women, n (%)	44 (39.6)
Crohn disease, n (%)	29 (26.1)
Ulcerative colitis, n (%)	82 (73.9)
Comorbid disease presence, n (%)	55 (49.5)
No of medications >3, n (%)	59 (53.2)
Low protein intake (b), n (%)	28 (25.2)
Mobile (c), n (%)	99 (89.2)
BMI (a) (kg/m2)	26.3 ± 4.4 (15 - 44)
Underweight (§), n (%)	1 (6.3)
Underweight (*), n (%)	5 (5.3)
Obese, n (%)	26 (23.4)
MNA-SF score (a)	10.6 ± 2.8 (3- 14)
Malnourished , n (%)	16 (14.4)
At risk of malnutrition, n (%)	45 (40.5)
MNA score (a)	22.1 ± 4.8 (9 - 30)
Malnourished , n (%)	18 (16.2)
At risk of malnutrition, n (%)	38 (34.2)
FFM (a) (kg)	54.1 ± 10.6 (33 -78)
FFMI (kg/m2)	19.4 ± 2.5 (13.4 – 24.8)
CC (a) (cm)	36.7 ± 3.6 (25 – 48)
4m GS (a) (s)	5.9 ± 2.0 (2 - 13)
HGS (a) (kg)	28.1 ± 9.5 (13-51)

CC: calf circumference, **BMI:** body mass index, **MNA-SF:** mini nutritional assessment short form, **GS:** gait speed, **FFM:** Fat free mass, **HGS:** Handgrip strength, **s:** seconds. a Mean ± SD (Min-Max) b Insufficent protein intake, less than once a day dairy product, meat or fish c Goes out of the house independently §<22 in patients >70 years of age *<20 in patients <70 years of age)

OP-18

EVALUATION OF HOSPITALIZED GERIATRIC PATIENTS WITH LIVER CIRRHOSIS

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Objective: Liver cirrhosis (LC) has different etiologies and causes more than one million deaths every year in the world. Hepatitis B (HBV) and C virüs (HCV) infections are the most important causes in Turkey, alcohol and other causes follow this. Among the first 20 diseases that caused death in Turkey in 2000, cirrhosis was reported to be in the 14th place in rural areas and 19th place in urban areas for ≥ 60 yeras of age. Diagnosis is made by the liver biopsy, and by clinical-laboratory and / or imaging methods. Child-Pugh and MELD classifications are reliable in determining the life span. We aimed to evaluate the sociodemographic, clinical and laboratory data of the cirrhotic elderly because of the insufficiency of epidemiological data related to LC in the geriatric age group, in this study.

Material and method: Ninety-nine patients aged ≥65 years diagnosed with LC who were hospitalized due to any complaints or cirrhosis complications within 18 months were taken. Sociodemographic data, reasons for hospitalization, etiology of cirrhosis, presence of esophageal varices (EV), biochemical data, MELD score, CHILD score, hepatocellüler carcinoma (HCC), and ascide presence, gradient of serum ascide albumin (SAAG), in the presence of spontaneous bacterial peritonitis; albumin, total protein, leukocyte level were assessed. Statistical analyzes were performed using the IBM SPSS Statistics 20 package program.

Results: The mean age was 71.7 ± 5.23 (41 female, 58 male). 59% of the patients were men. Reasons for hospitalization were; 28.3% HCC, 20.2% hepatic encephalopathy, 19.2% LC, 9.1% EV, 8.1% ascide, 15.1% other causes. Etiologies were : 24.3% HBV, 31.3% HCV, 29.3% Cryptogenic, 7.1% alcohol, 4% non alcoholic steatohepatitis and 1% HBV (with delta), primer biliary cirrhosis, primary sclerosing colangitis, alcohol plus HCV. In 77.8% of the cases there were EVs and 42.4% HCC, and 64.6% ascide. 11.1% died at the hospital. There were statistically significant differences between gender and etiology (p <0.003); EV presence and CHILD groups (p<0.0001), ascide (p=0.006), total bilirubine (p=0.011) and MELD (p=0.004); HCC and etiology (p=0.003), ascide (p=0.011) MELD (p=0.033), and CHILD score (p=0.003).

Conclusion: Hospitalization causes were HCC, hepatic encephalopathy and LC; and etiologic factors were HCV, cryptogenic cirrhosis and HBV (without delta), respectively. In most cases EVs were detected in which Child and MELD scores were found to be significantly higher and in the majority there was ascide. Majority of them were Child B and C group.

Keywords: liver cirrhosis, geriatric patients, hospitalized patients

OP-19

PHYSICAL ACTIVITY RELATED FACTORS IN ELDERLY

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Objective: Physical activity(PA) is defined as any bodily movement produced by skeletal muscles that requires energy expenditure such as occupational, sports, conditioning, household, other daily living activities and walking, cycling, or participating in sports activity. The aim of this study is to determine the PA levels of our outpatient elderly to investigate the related factors.

Materials and methods: We retrospectively reviewed the geriatric outpatient elderly of our medical faculty in 2013-16. A total of 1064 patients aged ≥65 years with no acute disease were been enrolled into the study. PA status and comprehensive geriatric assessment (CGA) were been queried and the objects were independent or assisted walking. As the CGA; demographic data, hand grip strength, falling and falling risk in the last 1 year, activities of daily living (ADL), instrumental activities of daily living (IADL), nutrition, frailty, chronic pain, sleeping problem, urinary incontinence, constipation, depressive mood, cognitive status, number of illness and medication were questioned. There were PAs who walked out of the house for any reason in last week. Those objects who did not walk out of the house or walked when they did not go out were accepted as PAs. There were who walked out of the house for any reason within last week, and those who did not walk out of the house or who did not walk were accepted as a non PAs.

Results: The mean age of the elderly was 78.5 ± 5.7(65-99). 88(33.7%) were male and 173 (66.3%) were female. The CGA parameters of the elderly with PA and non PA are shown in table.

Conclusion: In the non-PA group: The mean age (80→77), female (36%→20.2%), non-illiterate(40→10.5%), unmarried (52.5→38.8%) and those living alone(22.7%→11.3%). According to CGA in non PA group: Loss of appetite (36.3%→12.2%), nutritional problems(38.8%→15.5%), low muscle strength (66.3→39.8%), risk of falling(65%→18.8%), falling within the last 1 year (45%→32%) were found higher. In the non-PA group, dependency were (7.5%→0.6%), (45%→9.4%) in ADL and IADL respectively, and fragility rate (27.5→2% 8%), depressive mood (45.5%→16.6%), cognitive impairment (48.8%→25.3%), chronic pain (63.8%→43.6%), urinary incontinence (56.3%→35.9%), constipation (51.3% →23.8%) were higher. In logistic regression analysis: to be educated (OR 0.23, % 95CI 0.6-0.76 p=0.017), being independent in IADL (OR 0.26, %95CI 0.09-0.79 p= 0.017) and normal appetite (OR 3.90, %95CI 1.29-11.76 p=0.015) were found as independent factors associated with PA (model r^2 value 0.45).

Discussion: Findings in our study about physical activity in elderly suggests that education, functional status and nutritional status are important factors.

Keywords: elderly, physical activity, comprehensive geriatric assessment

Table 1. Relation to the study parameters of different physical activity level

	physical activity (-) n=80 (30.7%)	*physical activity (+) n=181 (69.3%)*	*p*
Age	80.3 ±5.8 (68-99)	77.7±5.5 (65-92)	0.001
Male	18 (20.2%)	71 (79.8%)	0.011
Female	62 (36.0%)	110 (64.0%)	0.011
Height	1.53±0.08 (1.35-1.87)	1.40±0.09 (1.40-1.87)	0.023
Weight	70.3±16.0 (44-128)	70.6±13.4 (38-114)	
Literate (-)	32 (40%)	19 (10.5%)	0.000
Married	31 (38.8%)	95 (52.5%)	0.041
Living alone (+)	9 (11.3%)	41 (22.7%)	0.038
Income (-)	18 (22.5%)	27 (14.9%)	
BMI	29.8±6.5 (19.5-53.3)	28.9±4.9 (16.9-47.7)	
Loss of appetite (+)	29 (36.3%)	22 (12.2%)	0.000
Nutrition problem (+)	31 (38.8%)	28 (15.5%)	0.000
Muscle strength (-)	53 (66.3%)	72 (39.8%)	0.000
Timed Up Go Test	18.7±9.6 (8-65)	11.4±4.2 (6-34)	0.000
Risk of falling (+)	52 (65%)	34 (18.8%)	0.000
Falling in 1 year	36 (45%)	58 (32%)	0.043
ADL (dependency)	6 (7.5%)	1 (0.6%)	0.004
IADL (dependency)	36 (45%)	17 (9.4%)	0.000
Frailty (+)	22 (27.5%)	5 (2.8%)	0.000
Depressive mood (+)	33 (46.5%)	29 (16.6%)	0.000
Cognitive impairment (+)	39 (48.8%)	44 (25.3%)	0.000
Watch drawing test (-)	49 (68.1%)	70 (40.0%)	0.000
Sleep problem (+)	46 (57.5%)	84 (46.7%)	
Chronic pain (+)	51 (63.8%)	79 (43.6%)	0.003
Incontinence (+)	45 (56.3%)	65 (35.9%)	0.003
Constipation (+)	41 (51.3%)	43 (23.8%)	0.000
Life quality (EQ5D)	8.8±1.9 (6-12)	7.02±1.7 (5-11)	0.000
Life quality (Eq5D %)	60.2±20.1 (20-100)	67.8±17.8 (15-100)	
Number of disease	5.0±2.1 (1-10)	4.2±2.0 (0-11)	0.016
Number of drugs	6.9±3.4 (1-16)	5.9±2.9 (0-13)	0.039

OP-20

HIGHER SERUM ENDOCAN LEVELS ASSOCIATED WITH COGNITIVE DECLINE AND ALZHEIMER'S DISEASE

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Aim: Recent studies suggest that angiogenic vascular factors like vascular endothelial growth factor may have a role in the pathogenic mechanism of Alzheimer's disease. Endocan is a novel molecule of which expression regulated by VEGF. It is secreted from human endothelial cells and suggested as a marker of endothelial dysfunction and inflammatory pathology and so it can be possibly related to the pathophysiology of AD. The aim of this study is to evaluate the relationship between the serum Endocan levels and cognitive status and Alzheimer's disease in geriatric population.

Material and Methods: Patients with Alzheimer's disease, amnestic mild cognitive impairment (MCI) and patients without cognitive impairment whom admitted to the geriatric medicine outpatient clinic of Hacettepe University Faculty of Medicine hospital were included in this study. Patients who have an inflammatory disease, malignancy, cerebrovascular event, peripheral artery disease, vascular dementia, Parkinson's dementia, lewy body dementia and frontotemporal dementia and other neurodegenerative diseases were excluded from the study. Cognitive status of the patients was evaluated by using MOCA and sMMSE. Serum endocan levels were measured with an enzyme-linked immunosorbent assay kit. The relationship of serum levels of Endocan with Alzheimer disease and cognitive status was evaluated.

Results: A total of one hundred and fourteen patients (47 patients with Alzheimer disease, 42 patients with MCI and 45 control patients) were included. Mean age was 77.3 ± 5.8. Seventy-two patients (53.7%) were female. The most common comorbidities were hypertension and urinary incontinence (64.9% and 37.3% respectively) There was no significant difference in the frequency of diabetes mellitus, hypertension and coronary artery disease between the three groups. Serum endocan levels were found significantly higher in Alzheimer's disease group (median (min-max) levels of serum endocan were 277.6 pg/ml (84.4-1005.9); 247.7 pg/ml (77-1067.8) and 380.1 pg/ml (158.2-2994) in control, MCI and Alzheimer's disease group, respectively). A weak but statistically significant negative correlation was found between the serum endocan levels and sMMSE and MOCA scores (r=-0.219 and r=-0.232; p=0.012 and p=0.010 respectively.) Serum endocan levels, dependency in instrumental activity of daily living and having higher nutritional risk were detected as independently associated factors of Alzheimer disease according to the multivariate analysis. The cut-off serum levels of endocan in predicting Alzheimer disease was found > 288.94 (AUC:0.71, 95%CI 66.7-90.9, sensitivity: 80.9%, specifity: 59.8%, positive predictive value: 52.1%, negative predictive value: 85.2%, p<0.001).

Conclusion: Serum endocan levels were correlated with the cognitive status and higher levels can predict Alzheimer disease. This study can support the role of angiogenic factors on Alzheimer disease. Further comprehensive studies are needed.

Keywords: Endocan, Alzheimer's disease

OP-21

MASKED HYPERTENSION CAUSES DECLINE IN COGNITIVE FUNCTIONS IN GERIATRIC AGE

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Background/Objectives: Ambulatory blood pressure measurement (ABPM) has become increasingly common in clinical daily practice in recent years (1). ABPM is an extremely valuable method for determining the cause and type of blood pressure which was detected high or variable in office measurements. Recent studies show that 10-40% of the patients, who were known as 'normotensive' previously, were diagnosed as 'hypertensive' after ABPM (1-4). This condition is called masked hypertension or isolated ambulatory hypertension. This phenomenon can only be diagnosed with ABPM. Effect of hypertension on cognitive functions is well known. However, the effect

of masked hypertension on cognitive functions is still unknown. The aim of this study is to examine the relationship between masked hypertension and cognitive functions.

Design: One hundred-two normotensive patients admitted to the Geriatric Medicine outpatient clinic were included. Exclusion criteria were hypertension, dementia, major depression, and usage of antihypertensive medication. All patients underwent ABPM procedures and average daytime blood pressure, mean blood pressure at night and the 24-hours average blood pressure measurements were recorded. Comprehensive geriatric assessment tests and neuropsychological tests were administered. The diagnosis of masked hypertension was based on the definitions in the 2013 guideline of the European Society of Cardiology (ESC).

Results: 44 patients (43%) were diagnosed with masked hypertension. Patients with masked hypertension had significantly lower scores on Mini-Mental State Examination (MMSE) test, Quick Mild Cognitive Impairment Test (QMCI) and Categorical Fluency Test than the control group (p = 0.011; p = 0.046; and p = 0.004; respectively). Montreal Cognitive Assessment Scale (MOCA) test score was lower in masked hypertension, although this was not statistically significant.

Conclusion: This study shows that geriatric patients with masked hypertension, compared to normotensive patients have decreased cognitive functions. ABPM should be performed to geriatric patients and cognitive assessment should be performed to masked hypertension patients is essential to diagnose cognitive dysfunction at early stage and take precautions on time.

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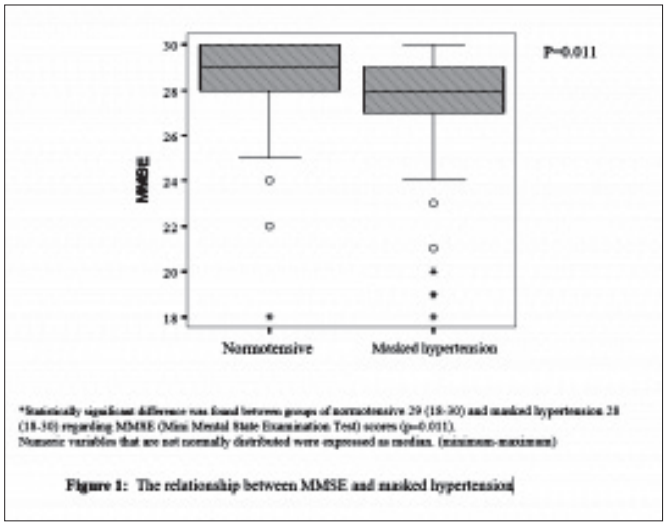
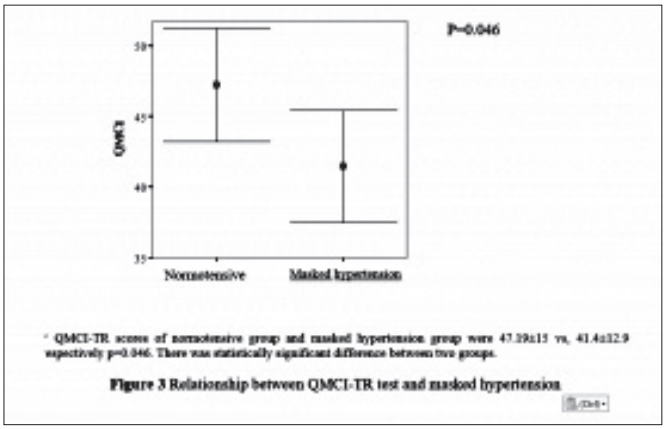
Keywords: Masked hypertension, cognitive functions, geriatrics



*Statistically significant difference was found between groups of normotensive 29 (18-30) and masked hypertension 28 (18-30) regarding MMSE (Mini Mental State Examination Test) scores (p=0.011).
Nonnemic variables that are not normally distributed were expressed as median. (minimum-maximum)

Figure 1: The relationship between MMSE and masked hypertension



* QMCI-TR scores of normotensive group and masked hypertension group were 47.29±15 vs. 41.4±12.9 respectively p=0.046. There was statistically significant difference between two groups.

Figure 3 Relationship between QMCI-TR test and masked hypertension

Table 1. Demographic Characteristics of Patients

	Total (n=102)	*Masked Hypertension (n=44)*	*Normotensive (n=58)*	*P value*
Age	71.92±5.72	72.89±5.53	71.19±5.79	0.13
Male	42 (41.2%)	19 (43.2%)	23(39.7%)	0.72
Female	60 (58.8%)	25 (56.8%)	35(60.3%)	0.72
Primary school/ illiterate	57 (55.9%)	30 (68.2%)	27 (46.6%)	0.11
Secondary school	15 (14.7%)	3 (6.8%)	12 (20.7%)	0.11
High school	11 (10.8%)	4 (9.1%)	7 (12.1%)	0.11
University	19 (18.6%)	7 (15.9%)	12 (20.7%)	0.11
Smoker	16 (15.7%)	6 (13.6%)	10 (17.2%)	0.47
Alcohol user	12 (11.8%)	5 (11.4%)	7 (12.1%)	0.91

Table 2. Results of Ambulatory Blood Pressure Measurements

	Total (n= 102)	*Masked Hypertension (n= 44)*	*Normal ABPM (n=58)*
Office measurements			
Systolic	128.3±12.0	130.2±10.5	126.8±12.9
Diastolic	79.5±8.8	80.1±8.3	79±9.1
Home self measurements			
Systolic	120.9±12	129.2±8.6	114.6±11
Diastolic	74.8±8.6	79.6±7.1	71.2±8
24hours Ambulatory measurements			
Systolic	124.8±10.2	133.8±6.4	117.9±6.7
Diastolic	68.3±7.3	70.7±7.2	66.5±6.9
Daytime Ambulatory measurements			
Systolic	126±10.3	134.5±7.5	119.6±7.1
Diastolic	69.6±7.8	71.6±7.7	68.1±7.1
Overnight Ambulatory measurements			
Systolic	116.4±14.7	129.9±10.6	106.4±7.6
Diastolic	61.7±8	65.9±7.1	57.4±6.5

Table 3. Results of Cognitive Assessment Test Scores

	Total (n=102)	*Masked Hypertension (n=44)*	*Normotensive (n=58)*	*P value*
MMSE	29 (18-30)	28 (18-30)	29 (18-30)	0.011
MOCA	17.6±5.7	16.4±5.6	18.5±5.6	0.07
QMCI-TR	44.7±14.4	41.4±12.9	47.19±15.1	0.046
Clock drawing	4(0-4)	4(0-4)	4(0-4)	0.3
Trail making A	46 (45%)	15 (32.6%)	31 (67.4%)	0.052
Forward Digit Span	4 (1-9)	4 (1-9)	4 (1-8)	0.6
Backward digit span	3.25±1.65	3.02±1.42	3.41±1.80	0.23
Categorical Fluency	15.67±4.2	14.3±4.23	16.7±3.96	0.004

MMSE: Mini-Mental State Examination test, **QMCI:** Quick Mild Cognitive Impairment Test
MOCA: Montreal Cognitive Assessment Scale

OP-22

EFFECT OF ANTICHOLINERGIC BURDEN ON THE DEVELOPMENT OF DEMENTIA IN OLDER ADULTS WITH SUBJECTIVE COGNITIVE DECLINE

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Aim: Data on the effect of anticholinergic burden (ACB) on cognitive status in older adults with subjective cognitive decline (SCD) are limited. We aimed to study whether ACB increases the future risk of dementia in older adults with SCD.

Methods: The analysis was carried out on 1496 older adults. Out of those, 109 older patients had been diagnosed with SCD at baseline and followed up over 36 months were studied. They were divided into two groups according to cognitive status at last visit: group I included the subjects with SCD who did not progress to dementia and group II included those who progressed to dementia. ACB was calculated for each subject by adding the score of each drug and classified as no or low ACB (ACB ≤ 2) and high ACB (ACB ≥ 3).

Results: Fifteen (13.8%) of 109 participants with baseline SCD developed dementia. High ACB was present in 12 subjects (12.8%) in group I and 7 subjects (46.7%) in group II (p=0.001). The 75-84 and 85+ age groups (HR=3.595; CI:1.117-11.574; p=0.032 and HR=12.203; CI:2.889-51.537; p=0.001, respectively), hypertension (HR=7.835; CI:1.020-60.1a89; p=0.048), and high ACB (HR=4.312; CI: 1.563-11.899; p=0.005) were found to be possible risk factors for dementia among subjects with SCD in the univariate model. In the final multivariate cox regression model, subjects with high ACB had a 4.2-fold the risk of the development of dementia.

Conclusion: High ACB is associated with an increased risk of dementia in older adults with SCD.

Keywords: Anticholinergic burden, dementia, older adults, subjective cognitive decline.

OP-23

EXAMINATION OF THE RELATIONSHIP BETWEEN ANTIOXIDANT RATIO AND CONTRAST INDUCED NEPHROPATHY IN ELDERLY PATIENTS

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Aim: Contrast-induced nephropathy (CIN), is the third most common cause of hospital-acquired acute kidney injury due to impaired renal perfusion and use of nephrotoxic medications(1). The incidence of CIN is less than 2% in patients with normal renal function without risk factors, but can increase to 9–40% in patients with mild to moderate chronic renal insufficiency(2). There is a need for new markers, which has predictive value becuse of frequency and morbidity of CIN. The aim of this study was to investigate the relationship between plasma thiol levels and CIN.

Materials and Methods: Serum samples were taken before contrast and 48 hours after contrast medium administration from 40 patients who required contrast-enhanced imaging during hospitalization. 25% increase in serum creatinine level was accepted as contrast-induced nephropathy. The relationship between change of antioxydant ratio and contrast nephropathy was examined.

Results: Contrast induced nephropathy developed in 10 patients (25%). There was a significant and negative correlation between total thiol(p<0,047/ r:-0,639) and disulfide values(p<0,06/ r:-0,605) in patients with CIN. Also there was istatistically significant association between total thiol measurement and low albumin (p<0,00/ r:0,654), Katz(p<0,041/ r:0,328) , MNA (p<0,003/r:0,459) , high CRP (p<0,011/r:-0,453) and ferritin (p<0,021/r:-0,364) levels in all patients who received contrast. These results indicate that the ratio of total thiol as an antioxidant parameter decreases in fragil older patients whom acute phase response is high. There was statistically significant association between disulphide measurement as an oxidation product and sedimentation (p<0,027/ r:0,374) ,ferritin (p<0,000/ r:0,562) levels in all patients who received contrast. At 0 and 48. hours serum anti-oxidant ratios showed non-significant decrease in total and native thiol levels and a non-significant increase in disulphide ratios.

Conclusion: The balance of oxydant and antioxydant status plays an important role in the CIN. Thiol is an important part of antioxidant system in the body. In our study, we showed that patients with low levels of total thiol and disulfide are predisposed developing contrast nephropathy. The reason of nonsignificant change between 0 and 48. hours total thiol and disulphid ratio may be caused by giving N-asetyl systein.

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Keywords: contrast induced nephropathy, antioxidant, older

Table 1. Correlation between anti-oxydant markers and labaratory /functional parameters

	CIN	Albumin	Sedimentation	CRP	Ferritin	Katz scale	MNA
Native Thiol	r:-0.484 p:0.156 n:10	r:0.588 **p:0.000** n:40	r:-0.339 **p:0.046** n:35	r:-0.438 **p:0.005** n:39	r:-0.529 **p:0.000** n:40	r:0.381 **p:0.017** n:39	r:0.419 **p:0.008** n:39
Total Thiol	r:-0.639 **p:0.047** n:10	r:0.654 **p:0.000** n:40	r:-0.239 p:0.167 n:35	r:-0.403 **p:0.011** n:39	r:-0.364 **p:0.021** n:40	r:0.328 **p:0.041** n:39	r:0.459 **p:0.003** n:39
Disulphide	r:-0.605 p:0.064 n:10	r:0.164 p:0.312 n:40	r:0.374 **p:0.027** n:35	r:0.138 p:0.403 n:39	r:0.562 **p:0.000** n:40	r:-0.188 p:0.252 n:39	r:0.099 p:0.548 n:39

CIN: Contrast induced nephropathy
CRP: C-reactive protein
MNA: Mini nutritional assessment
r: correlation coefficient

OP-24

THE RELATIONSHIP BETWEEN SOCIODEMOGRAPHIC CHARACTERISTICS, COGNITIVE STATUS AND QUALITY OF LIFE IN ELDERLY

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Introduction: There are many factors that affect negatively the quality of life in older people. We aimed to investigate the relationship between sociodemographic characteristics, cognitive status and quality of life in community dwelling elderly.

Method: The study included 152 patients of the geriatric rehabilitation unit, department of Physiotherapy and Rehabilitation, Hacettepe University. Socio-demographic characteristics such as age, gender etc. were recorded. The cognitive status of elderly was assessed by the Mini Mental State Examination (MMSE) and quality of life assessed by SF-36.

Results: This study included 55 male and 97 female. Their average ages were 73.5 ± 6.75 years. There was a statistically significant positive correlation between duration of education, MMSE score and all subscales of SF-36 ($p<0.05$). It was found that statistically significant negative correlation between the number of medications used, BMI and all the subscales of SF-36 except for "Emotional Role" ($p<0.05$).

Discussion: It has been shown that worsening of the cognitive state, decreasing levels of education, increasing body mass index and increasing medications have affected negatively quality of life of elderly in our study. For improve the quality of life; It is important that the regulation of medication numbers, reduction of obesity with healty nutrition and increased physical activity. Individual-specific exercise programs increase the quality of life by preventing falls and improving cognitive status.

Keywords: Cognitive, quality of life, elderly

OP-25

ASSOCIATION BETWEEN PHASE ANGLE DERIVED FROM BIOELECTRICAL IMPEDANCE ANALYSIS AND FRAILTY AMONG ELDERLY POPULATION

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Introduction: Phase angle detected by using bioelectrical impedance analysis is a parameter that was shown in previous studies to be related with sarcopenia and malnutrition in the elderly population. There is not enough data showing relationship between phase angle and frailty. In this study, we have planned to show whether there is an association between these parameters or not.

Material and Methods: A hundred eighty eight elderly patients (age over 65) were included in the study. All patients underwent comprehensive geriatric assessment. The frailty status of the patients were evaluated by Fried's Frailty Index which has five components including weight loss, weakness, exhaustion, low activity and slow speed walking. There or more positive results in this scale were considered as frail, 1-2 points were as pre-frail and none of these criteria was considered as robust. All patients were evaluated by using bioelectrical analysis device to determine phase angle.

Results: The median age of the patients were 74 years (min-max: 65-91) and 41.5% were female. The most common co-morbidities were hypertension (75.5%) and diabetes mellitus (41.0%). Phase angle was lower in frail group than pre-frail and robust groups (4.12±0.79 vs. 4.60±0.63 vs. 5.20±0.80, respectively) ($p<0.001$). The parameters which were significantly different ($p<0.2$) in univariate analysis were included in multivariate analysis and phase angle (OR: 0.360, p= 0.018), age (OR: 1.132, p= 0.020), mini-mental state examination (OR: 0.777, $p<0.001$) and Yesavage geriatric depression scale (OR: 1.307, p= 0.002) were found to be independently associated factors for frailty. Receiver operating characteristic (ROC) analysis suggested that optimum cut-off point of phase angle for frailty was ≤4.00 with 54.8% sensitivity, 91.0% specificity, 54.8% positive predictive value and 91.1% negative predictive value (AUC: 0.751, $p<0.001$).

Conclusion: This study has demonstrated that phase angle may be an independently associated factor for frailty. Further prospective studies are needed to investigate casual relationships between these entities.

Keywords: Phase angle, bioelectrical impedance analysis, sarcopenia, malnutrition

OP-26

HYPOTENSION IN NURSING HOME RESIDENTS ON ANTIHYPERTENSIVE TREATMENT: HOW SIGNIFICANT IS IT?

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Objective: Prevalence of hypertension (HT) and use of antihypertensive medications increase by aging. Antihypertensive-medication is a potential risk factor for hypotension for morbidity/mortality in elders. We aimed to assess prevalence of hypotension and orthostatic hypotension (OHT) and their relationship between subsequent one-year hospitalization and mortality in nursing home (NH) residents receiving antihypertensive-medications.

Methods: A group of NH resident >60 years of age receiving antihypertensive medications accepted to involved. Blood pressures (BPs) were measured sitting and 3-5 min after standing to assess OHT. BPs were measured supine and 3-5 min after sitting to assess OHT in bedridden residents. Also BP measures recorded in the last year at NH have been studied retrospectively. Residents were evaluated for both recorded and current BPs and comprehensive geriatric assessment thoroughly.

Results: 175 were male (%66) and 89 were female (%34) from 264 subjects. Mean age was 75.7±8.7 years. Ratio of residents regarding mobility situation were as follows: Bedridden (n=10, %6,6), wheelchair-bound (n=35, 19.4%), need for assistance for ambula-

tion (n=18, 10%), ambulate (n=117, 65%). At one year, ratio of hospitalization from any cause was 50.8% (n=134), mortality rate was 21.6% (n=57), falls ratio was 31.7% (n=60). 88 residents had mean SBP <=110 mmhg (34.8%). 40 residents had mean DBP<=65 mmhg (15.8%). 54 residents had OHT (21.6%). Lower SBP (<=110 mmhg) was statistically significant predictor of mortality (p=0,040) in cox regression analysis after adjusting for age, number of comorbidities and medications, body-mass index. Mortality was significantly higher in residents with mean DBP <=70 mmhg (p=0,031) in chi-square analysis. Hospitalization was higher in only group with DBP<=65 mmhg with borderline statistical significance (p=0,05).

Conclusion: Both supine hypotension and OHT are significantly prevalent in 'hypertensive' NH residents on antihypertensive-treatment. Either lower SBP<=110 mmhg or DBP <=70 mmhg is associated with mortality in NH residents. Lower DBP <=65 mmhg is also associated with increased hospitalization in NH residents.

Keywords: hypertension, anthihypertensive treatment, mortality

OP-27

THE ASSOCIATION OF SERUM 25-(OH) VITAMIN D, VITAMIN B12 AND B9 LEVELS WITH GASTRIC AND COLORECTAL CANCERS IN THE ELDERLY

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Aim: Folic acid and vitamin B12 play essential roles in DNA synthesis, methylation, cell repair and regulation of gene expression. Vitamin D receptors are expressed by almost all nucleated cells and vitamin D is important for various cellular mechanisms including cell cycle control and apoptosis. The associations of cancer and serum 25-hydroxy vitamin D (25-(OH) vitamin D), vitamin B12 and folic acid levels were assessed in various studies with conflicting results. In this study, we evaluated the association of gastric and colorectal cancers and 25-(OH) vitamin D, vitamin B12 and folic acid levels in the elderly patients.

Method: Patients from the Central Anatolia region, aged 65 or older, who underwent upper and/or lower gastrointestinal endoscopy between 2007 and 2017 were included. Medical records of 367 patients with upper gastrointestinal endoscopy and 227 patients with colonoscopy results were retrospectively reviewed. Age, gender, histopathological findings, comorbidities, 25-(OH) vitamin D, vitamin B12, folic acid, iron profile and complete blood count results were recorded. Twenty-six patients were excluded because of missing vitamin levels. Charlson comorbidity index (CCI) scores were calculated. Patient groups with and without cancer were compared with chi-square and Mann-Whitney U tests, where appropriate.

Results: Twenty out of 367 patients (5.4%) who underwent upper gastrointestinal endoscopy had gastric adenocarcinoma, and 17 out of 227 patients (7.5%) who underwent colonoscopy had colorectal cancer. Patient groups with or without gastric and with or without colorectal cancers were similar in terms of age, gender, presence of anemia and comorbidities. There were no significant differences in the levels of 25-(OH) vitamin D (p:0.280) , vitamin B12 (p:0.05), and folic acid (p:0.993) between patients with and without colorectal cancer (Table 1). Patients with gastric adenocarcinoma had significantly lower levels of 25-(OH) vitamin D compared to patients without gastric adenocarcinoma (median levels 13.6 vs 7.1 ng/mL, p:0.035), whereas vitamin B12 (p:0.895) and folic acid (p:0.488) levels were similar (Table 2).

Conclusion: In our study, 25-(OH) vitamin D levels were significantly lower in patients with gastric adenocarcinoma. On the other hand there were no differences in patients with colorectal cancer. Overall, the results of studies examining the association of cancer and vitamin D are inconsistent. The potential role of vitamin D in tumor pathogenesis, and cancer prevention by dietary modifications, increased sun exposure and vitamin D supplementation should be evaluated in prospective clinical trials. For patients with vitamin D deficiency, vitamin D supplementation may potentially reduce the risk of some cancer types, in addition to preventing osteopenia and osteoporosis.

Keywords: 25-Hydroxy vitamin D, vitamin B12, folic acid, gastric cancer, colorectal cancer

Table 1. Lower gastrointestinal endoscopy results

		Colorectal cancer (-)		Colorectal cancer (+)		p
		n	%	n	%	
Total		210	92.5	17	7.5	
Gender						
	Female	122	58.1	9	52.9	0.679
	Male	88	41.9	8	47.1	
Age-years, median (range)		78	(65-93)	79	(69-88)	0.945
Age group						
	65-74	70	33.3	7	41.2	0.775
	75-84	117	55.7	8	47.1	
	≥85	23	11	2	11.7	
Anemia						
	No	39	18.6	1	5.9	0.319
	Yes	171	81.4	16	94.1	
Iron-deficiency anemia						
	No	53	25.2	2	11.8	0.375
	Yes	157	74.8	15	88.2	
25-(OH) vitamin D (ng/mL), median (range)		12.4	(0.4-76.2)	9.2	(4.2-26.3)	0.280
Vitamin B12 (pg/mL), median (range)		310	(76-3170)	429	(130-2000)	0.050
Folic acid (ng/mL), median (range)		7.6	(0.9-33)	8.1	(3.8-20)	0.993
CCI, median (range)		6	(3-18)	6	(3-7)	0.635

CCI: Charlson comorbidity index

Table 2. Upper gastrointestinal endoscopy results

		Gastric cancer (-)		Gastric cancer (+)		p
		n	%	n	%	
Total		347	94.6	20	5.4	
Gender						
	Female	208	59.9	9	45	0.186
	Male	139	40.1	11	55	
Age-years, median (range)		78,2	(65 - 99)	73.7	(65-91)	0.104
Age group						
	65-74	114	32.9	11	55	0.095
	75-84	185	53.3	6	30	
	≥85	48	13.8	3	15	
Anemia						
	No	92	26.5	8	40	0.188
	Yes	255	73.5	12	60	
Iron-deficiency anemia						
	No	127	36.6	8	42.1	0.628
	Yes	220	63.4	11	57.9	
25-(OH) vitamin D (ng/mL), median (range)		13,6	(2.6-117)	7.1	(5.3-49.4)	**0.035**
Vitamin B12 (pg/mL), median (range)		329	(50-2000)	356	(77-1077)	0.895
Folic acid (ng/mL) , median (range)		7,4	(0.9-33)	6.6	(3-24)	0.488
CCI, median (range)		6	(3-14)	5	(3-7)	0.185

CCI: Charlson comorbidity index

OP-28

RESULTS OF PERCUTANEOUS ENDOSCOPIC GASTRIC TUBE INSERTION IN THE DEMENTED AND FACTORS RELATED WITH CAREGIVER PLEASURE

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Background: Growing number of patients receive percutaneous endoscopic gastric tube insertion (PEGTI) as frequency of dementia

and progression to severe dementia increases. It is well known that feeding problem of a demented patient is an important stress factor for the caregivers. After PEGTI feeding problem is vanished but there is not enough data from the perspective and pleasure of caregiver. In this study we aimed to detect the factors affecting survival, complication rates and pleasure of caregivers after PEGTI.

Methods: Laboratory and clinical data of 62 patients with PEGTI were screened retrospectively those were hospitalized between January 2008 and January 2016. Age, sex, follow up duration, comorbidities, drugs, complications, hospital stay after PEGTI and laboratory results were recorded. 52 caregivers of 54 patients whose survival was more than one month after PEGTI were included in this study. Caregivers were wanted to fill a short questionnaire were to determine their perspective for PEGTI. Factors affecting survival and pleasure of caregivers after PEGTI were determined.

Results: Mean age of the patients were 83 years old. Median follow up duration of patients with PEGTI was 11.07 (0.2- 66.9) months. Mortality rates after 30 days, 3 months, 6 months and 12 months were 12.90 %, 27.41%, 37.09 % and 46.77 % respectively. Minor complication rates, serum albumin level and CRP level were found to be independent factors related with mortality in multivariate analysis (OR=0,002, 95% CI=0,000-0,435 p=0,023, OR=0,015, 95% CI =0,000-0,628 p=0,028 and OR=1,124, 95% CI=1,005-1,257 p=0,040 respectively). Serum albumin and hemoglobin levels were found to be independent factors related with caregiver pleasure (OR=8,405, 95%CI=1,759-40,159 p=0,008 and OR=2,096 95% CI =1,016-4,321 p=0,045 respectively). Survival of the patients whose caregivers were pleased were longer when compared [28.2 (95%CI:24,55-31,90) vs. 17.7 months (95% CI:0,72-34,67), p=0,030]. 41 (78.9 %) caregivers declared that PEGTI is a method for nutrition that they will offer for other patients(%78,9).

Conclusions: PEGTI is a reliable method of nutrition with minimal complications when suitable patient selection is done, and has a similar survival rate in demented patients when compared with PEGTIs of other indications. PEGTI meets expectations of caregivers and has a high pleasure rate among caregivers of demented patients.

Keywords: percutaneous endoscopic gastric tube, dementia, caregiver, pleasure

OP-29

SENILE OSTEOPOROSIS IS ASSOCIATED WITH ENDOTHELIAL DYSFUNCTION

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Objective: Osteoporosis and cardiovascular diseases, which are common problems with aging, are seen as different diseases but accumulating evidence indicates that they may share similar pathophysiological mechanisms. One of the early predictor of atherosclerosis is endothelial dysfunction. The aim of this study was to evaluate the presence of endothelial dysfunction between normal, osteopenic and osteoporotic older adults.

Methods: 93 patients admitted to our outpatient clinic were enrolled in this study. All patients underwent comprehensive geriatric assessment and evaluated for osteoporosis or ostepenia and cardiovascular risk factors. Patients were classified into three groups according to bone mineral density (BMD) results; normal (T-score: ≥-1.0×S.D.), osteopenia (T-score between -1.0 and -2.5×S.D.), and osteoporosis (T-score: ≤-2.5×S.D.). As an indicator of endothelial dysfunction flow-mediated dilation (FMD) was measured by high resolution ultrasound in brachial artery of patients after a 5-minute block of artery blood flow through a cuff insufflated at suprasystolic blood pressure. Normal endothelial function were defined as > %10 change from basal arterial diameter.

Results: Within 93 patients, 59(63.4%) were women, 34(36.6%) were men, and mean age was 74.5±4.6. Groups were equally matched for cardiovascular risk factors. Among 23(%29) normal, 37(39.8%) osteopenic and 29(31.2%) osteoporotic patients FMD results were 11(IQR 7.3-15.0), 7.1(IQR 4.2-12.3), 7(IQR 5.0-9.5), respectively. Flow mediated dilation of the brachial artery showed a statistically significant better dilation of the brachial artery post cuff deflation in healthy controls than patients with ostepenia or osteoporosis (p:0.013).

Conclusion: Our findings revealed that osteoporosis is associated with endothelial dysfunction in older people.

Keywords: Senile osteoporosis, endothelial dysfunction, flow mediated dilation

OP-30

BURDEN, QUALITY OF LIFE AND COPING STRATEGIES OF PALLIATIVE CARE PATIENTS CAREGIVERS

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Introduction: Socioculturally, the care of the patient is usually provided by family members in our country. Since becoming a caregiver is not selectable and can not be planned; adaptation to this situation occurs after the occurrence of the situation. Caregiver burden is defined as negative objective and subjective results experienced by caregiver such as physical and mental health problems, economic and social problems, deterioration of family relations and feeling of not being in control itself.

Especially, determining the sociodemografic variables, the risk groups for care giver burden, coping strategies and quality of life is important in the caregivers of chronic disseases for planning preventive mental health services for these people.

The aim of this study is to determine the caregiver burden, coping strategies and quality of life in the caregivers of the patients in palliative care unit.

Method: This study was conducted between February and April 2016 in the caregivers of the patients at the Palliative Care Unit. Ethics Committee approval for the study was obtained. Patient relatives who volunteered to participate in the study were informed. An informed consent form has been signed by the participants. After all self report scales Zarit Caregiver Burden Scale, SF 36 and COPE were filled by the participants with the help of social services specialist.

Results: The mean age of the patients in the palliative care unit was 74,2±14,22. 59 . 32 (54.2 %) of the patients were female and 27 (45.8%) of the patients were male. The mean age of caregivers was 44,1±12,42. 34 (57.6%) of them were female and 25 (42.4%) were male.The mean score of Zarit Caregiver burden scale was 50,7 whic is interpreted as moderate burden. The highest score in the sub-

scale of COPE was cope 7 which is interpreted as religious coping strategy and the lowest score was cope 12 which is interpreted as substance use. Also emotional-focused coping score was the highest and non functional coping scale was the lowest in our study. There was positive corelation between Zarit caregiver burden scale and cope 2 subscale (R=0,280; p=0,032). There was no significant corelation between Zarit caregiver burden scale and the the sociodemografic data of the patients.

Conclusion: In our study we found the highest score in the subscale of COPE was cope 7 which is interpreted as religious coping strategy and the lowest score was cope 12 which is interpreted as substance use. It can related with the sociocultural characterics of our region. We found moderate burden in the caregivers. It can be related as the study was conducted in inpatient clinic. These findings suggest that caregivers need the support of health professionals in order to be able to cope with the difficulties they may face and to reduce the caregiver burden, especially in the inpatient clinics

Keywords: caregiver,palliative care unit

OP-31

DETERMINING THE EVALUATİON OF PAIN SYMPTOMS OF HEALTH PERSONNEL WORKING WITH PATIENTS WHO CAN NOT EXPRESS PAIN

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Aim: Elderly patients may not be able to express their pain verbally due to organic or neurocognitive disorders. In various studies, pain behaviors of patients who can not express their pain have been examined.One of these studies is the American Geriatrics Society's 'AGS Panel on Persistent Pain in Older Persons'. In this study, we aimed to investigate the state of understanding of pain symptoms of health personnel working with patients who can not express their pain.Materials and Methods: 57 health personnels working with patients who can not express their pain in a nursing home were included to the study. They were asked the most important 10 pain signs from 25 pain behaviors in the AGS Panel.Results: The percentage 45.6% of the personnel involved in the study (n:26) were caregivers, 8.8% (n: 5) were elderly care technicians, 31.6% (n :18) were nurses and 14% (n :8) were physiotherapist. 18.8% (n: 1) of the staff were 20 years old or younger, 36.8% (n: 21) were 21-30 years old, 26.3% (n:17) were 41-50 and 5,3% (n: 3) were between the ages of 51-60. We observed the most important signs of pain as a symptom of the AGS panel were grimacing, wrinkled forehead and closed or tightened eyes (17%). The second most important signs were sighing, moaning and groaning (14%). And the third was any distorted expression (10%).

Conclusion: The results from our study suggest that it is important to increase awareness of pain symptoms by in-service training of health personnel working with elderly patients who can not express their pain.

Keywords: pain behavior, older person, AGS Panel

OP-32

THE NURSING STUDENTS' AWARENESS OF THE ELDERLY ABUSE AND ATTITUDES OF THE ELDERLY

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Introduction: The health care professionals will have to deal with more elderly patients' health care because of the increasing number of elderly people. The nursing students who are studying in the faculties at the moment will take charge in the healthcare service after their graduation. Therefore, the nursing students' attitudes and behaviours toward the elderly patients are important.

Aim: This study was conducted in an effort to examine the nursing students' awareness of the elderly abuse and attitudes towards the elderly.

Material and Method: The study designed as a cross-sectional descriptive research was performed with the 1st, 2nd, 3rd, and 4th grades nursing students in Faculty of Nursing, Akdeniz University. The sample of the research was determined using $n=Nt^2p.q/d^2 (N-1) + t^2p.q$ formula at the 95% confidence level and calculating the size of stratified sampling. The sample of the research comprised of 410 students from all grades. The data of the study was collected by using Ageism Attitude Scale (AAS) and a two stage survey questionnaire designed by the researchers to acquire information on students' demographic characteristics, opinions on the elderly patients and their abuse.

Findings: Of the respondents in this study, 70% stated the possibility of physical abuse of the elderly, 65.6% psychological abuse, 79.8% financial abuse, 22.9% sexual abuse and 73.2% neglecting the elderly. 84.9% of the students answered no to the question "The nurses are not responsible to report the elderly abuse." Moreover, 96.3% students defined the mental inability as a risk for the abuse, 94.4% lack of social support, 89% financial difficulties. 68.8% of the students reported that the elderly women can be abused less. Ageism Attitude Scale (AAS) total score is 69.24±6.66. When the students' gender, relationship with the elderly in their family and working with the elderly in the training courses are taken into consideration, a statistically significant difference between AAS total score averages was identified ($p<0.05$)

Keywords: Elderly, Abuse, Attitudes,Awareness, Nursing Students

OP-33

FRAILTY AND CHRONIC PAIN: A NOVEL ASSOCIATION

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Objective: Frailty is most often defined as a syndrome of physiological decline in late life, characterized by marked vulnerability to adverse health outcomes. Frail older adults are less able to adapt to stressors such as acute illness or trauma than younger or non-frail older adults. This increased vulnerability contributes to increased risk for multiple adverse outcomes, including procedural complications, falls, institutionalization, disability, and death. We aimed to assess prevelance of frailty in elder people and it's relationship with other conditions in this study.

Methods: 1107 individuals >=60 years of age admitted to Istanbul Medical School Geriatrics outpatient clinic for the first time the period between 2013-2016 were enrolled to study. We used The In-

ternational Assosiation of Nutrition and Aging's FRAIL scale contains 5 simple questions to define frailty. Frail person was accepted as who gets >=3 points in scale. Patients were asked about their fallings, urinary incontinence, chronic pain, sleep disorders, activities of daily living (ADL), instrumental activities of daily living (IADL) , cognitive status, number of illness and medication, postural instability and assessed about their nutritional status by Mini Nutritional Assessment (MNA).

Results: 1107 patients were analyzed with a geriatric assessment. The sample was composed of women (66.8%) and men (33.2%) with mean age of 78.5 ± 5.7 years. Prevalence of frailty was 16% (n=179). Correlation analyses and multivariate regression analysis were performed to investigate the association between frailty and other factors. In multivariable analysis frailty was found independently assosiated with age (p=0.041) , chronic pain (p=0.021) , usual walking speed (p<0.01) , malnutrition (p<0.01) , instrumental activities of daily living (IADL) (p=0.024) respectively.

Conclusion: Frailty is a common clinical syndrome in older adults, which carries an increased risk for poor health outcomes, including falls, incident disability, hospitalization, and mortality. Elucidating its etiology and natural history is therefore critical for identifying high-risk subsets and new arenas for frailty prevention and treatment. An important strenght of our study is assessment of chronic pain which is a new area of research in frailty concept. Our findings provides data on the significance of chronic pain and its association with frailty.

Keywords: frailty, chronic pain, usual walking speed, instrumental activities of daily living, malnutirition

OP-34

THE RELATIONSHIP BETWEEN FRAILTY AND OSTEOSARCOPENIA IN GERIATRIC PATIENTS

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Introduction: Osteosarcopenia defined as the elderly patients with both sarcopenia and osteoporosis has been shown to be related with worse clinical outcomes of the elderly patients, but limited data are presented in the literature. Its association with frailty is not well described before. We designed a study to show the association between frailty and osteosarcopenia in the elderly patients.

Material and Methods: One hundred elderly patients, who had bone mineral densitometry (BMD) performed on a routine basis within last one year, were enrolled in the study. All patients were evaluated by comprehensive geriatric assessment. Diagnosis of sarcopenia was done according to the criteria of the European Working Group on Sarcopenia in Older People. Osteosarcopenia was considered when both sarcopenia and osteoporosis were present. Frailty status of the patients were evaluated according to the Fried's Frailty Index including five domains weight loss, weakness, exhaustion, low activity and slow walking speed. The patients with three or more deficits in five components were considered as frail, with 1 or 2 deficits were as pre-frail and no deficits was as robust.

Results: The median age of the one hundred patients (11 "sarcopenic and non-osteoporotic", 12 osteosarcopenic and 77 non-sarcopenic) were 75 years (min-max: 65-90) and 51.0% were male. Frailty status of the patients was as follows: 21% frail, 44% pre-frail and 35% robust. Frailty was more common in osteosarcopenic patients compared to "sarcopenic and non-osteoporotic" and non-sarcopenic groups (66.7%, 27.3% and 13.0%, respectively) (p<0.001). Osteosarcopenia was found to be associated with frailty in univariate analysis (OR: 11.5, p<0.001). Low handgrip strength and calf circumferences, higher age, slow walking speed, lower body mass index (BMI), frailty, decreased scores of basic and instrumental activities of daily living (ADL), clock drawing test, mini-mental state examination and mini-nutritional assessment-short from (MNA-SF) were shown to be associated with osteosarcopenia (all parameters had p<0.05). In multivariate analysis, age (OR: 1,395, p=0,023), instrumental ADL (OR: 0.550, p=0.042), female gender (OR: 43.203, p=0.012) and BMI (OR: 0.507, p=0.004) were detected to be independently associated factors with osteosarcopenia.

Conclusion: Our results suggest that frailty rate in osteosarcopenic patients may be more than other sarcopenic and non-sarcopenic patients. Further studies with large number of patients are needed to show the exact relationship.

Keywords: Osteosarcopenia Frailty

OP-35

INVESTIGATING THE DIFFERENCES OF STROKE SEVERITY AND LEVEL OF INDEPENDENCY INFLUENCES IN ELDERLY ACUT STROKE PATIENTS

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Objective: In elderly individuals, motor function, balance and mobility interactions after stroke can be added to age-dependent losses. This situation also affects the independence of the individual negatively. Although these special needs have been known, there are limited studies on physiotherapy necessity in elderly stroke patients in literature. The aim of this study was to determine the differences between 65 years and older patients and younger than 65 years old with acute stroke for stroke severity, motor function, level of independence and balance defects.

Materials and Methods: Twenty-eight patients with acute stroke diagnosed by the neurologist and inpatient at the neurology service of the study and research hospital were included in this study. Patients were divided into two groups according to their age as the control group with younger than 65 years old patients and the study group with 65 and over years old patients. The patients who were reported as clinically stable by the neurologist were informed about the study. The assessment methods were applied by the same physiotherapist to patients who voluntarily accepted to participate in to this study. The participants were assessed by National Institutes of Health Stroke Scale (NIHSS) for stroke severity, Stroke Rehabilitation Assessment of Movement (STREAM) for motor functions, Barthel Index (BI) for independence levels and Berg Balance Scale (BBS) for balance.

Findings: The median ages of the study and control group were 56 and 76 years, respectively. The median values of the groups were 3 and 5 in NIHSS, 63 and 42 in STREAM, 85 and 68 in BI, 45 and 14 point in BDS, respectively. There was a significant difference between STREAM scores of the study group and control group (p = 0.11) but no significant difference was detected between the other parameters (p <0.05). Nevertheless, there was a difference close to the level of significance between the NIHSS and barthel values of the groups.Very strong, significant positive correlations were determined between STREAM, BBS and BI scores in both groups (p <0.001). There were a strong, significant, negative correlations were obtained between NIHSS and STREAM, BBS and BI (p <0.001).

Conclusion: The defect of motor function was more in stroke patients 65 and over years of age than in patients younger than 65 years of age. The results of this study have been demonstrated the necessity of evaluating independence level, balance and stroke severity especially in elderly stroke patients who were significantly influenced by these parameters than younger's. It has been thought that it would be useful to perform more varied, customized, detailed, and elaborate

assessments of stroke impacts for stroke patients 65 and over years of age in comparison to the patients under 65 years of age to determine their lost in motor functions and needs in routine clinical practice.

Keywords: stroke in elderly, acute stroke, motor function, the level of independence

Table 1. Comparison of group measurements

	Group 1 Median(min-max)	Group 2 Median (min-max)	P
BMI	28,68 (23,87-35,16)	28,68 (22,86-40,42)	0,836
STREAM	63,00 (29,00 -70,00)	42,00 (0,00-68,00)	0,012*
BARTHEL	85,00 (10,00-100,00)	40,00 (0,00-100,00)	0,054
BERG	45,00 (3,00-54,00)	14,00 (0,00-53,00)	0,068
NIHSS	3,00 (0,00-6,00)	5,00 (0,00-20,00)	0,058

Table 2. Correlations between scores

	AGE	NIHSS	STREAM	BERG	BARTHEL
AGE	1,000	0,318	-0,432	-0,293	-0,307
NIHSS	0,312	1,000	-0,673	-0,616	-0,630
STREAM	-0,432	0,318	1,000	0,907	0,921
BERG	-0,293	-0,616	0,907	1,000	0,897
BARTHEL	-0,307	-0,630	0,921	0,897	1,000

OP-36

DETERMINATION OF PARATHYROID HORMONE REFERENCE VALUES IN OLDER ADULT: PRELIMINARY RESULTS OF AN ONGOING STUDY

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Introduction: Parathyroid hormone (PTH), which is one of the hormones in modulating calcium and phosphorus, has an important role in maintaining bone remodeling. Until now, there is no a PTH reference range obtained from vitamin D status in older adults. In addition, it is debatable whether the values currently used are appropriate for older adults. The purpose of this study is to determine the reference values of PTH in older adults, after eliminating many confounding factors.

Methods: 510 older adults were enrolled into the study. Out of those, 418 (82.0%) with 25-hydroxvitamin D [25(OH)D] concentrations <20 ng/mL, diabetes mellitus, chronic kidney disease (estimated glomerular filtration rate-GFR <35 mL/min), currently or past in 3 months on vitamin D treatment, and missing PTH values were excluded from the study. Fasting serum 25(OH)D and intact serum PTH concentrations were measured by the HPLC system and the E-170 immunoanalyzer, respectively. BMD of the total lumbar spine, total femur and neck were measured by dual-energy X-ray absorptiometry and expressed in absolute values (g/cm^2). Reference values of PTH were defined as the 2.5th and 97.5th percentiles according to 25(OH)D concentrations, ≥20 ng/mL and ≥30 ng/mL. Linear relationship of serum PTH concentrations with other variables was tested by Pearson's correlation analysis. To determine factors effecting on serum PTH concentrations, clinically significant factors including age, gender, BMI, season, and serum 25(OH)D were entered in a model for multiple regression analysis.

Results: 92 participants, with a mean age of 74.07±5.86 (ranged from 65 to 91) years, 43 (46.7%) female, and a mean BMI of 29.32±4.52 kg/m2 (ranged from 18.63 to 44.83), were included in the analysis. PTH reference values were determined as 19.40 – 101.90 pg/mL in whole sample, 23.0 – 98.0 and 27.80 – 74.20 in subjects with 25(OH)D ≥20 ng/mL and ≥30 ng/mL, respectively. Serum PTH concentrations were negatively correlated to 25(OH)D (r=-0.354, p=0.001), but not to calcium, phosphorus, magnesium, total lumbar spine, total femur and neck (p>0.05 for all comparisons). In multivariable regression analysis, only each unit decrease in serum 25(OH)D concentrations was found to be independent risk factor for each unit increase in serum PTH concentrations (OR=-1.009; CI:-1.608-0.409; p=0.001).

Conclusions: PTH reference values were determined for the first time in older adults in this study. Serum PTH concentrations was correlated to serum 25(OH)D levels, however not to BMD values. To clarify this issue and obtain best results, large studies are needed in older population.

Keywords: Parathyroid hormone; reference values; older adult

OP-37

DETERMINATION OF WALKING SPEED AND BALANCE STATUS ACCORDING TO AGE, GENDER AND FALLING HISTORY OF OLDER PEOPLE

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Introduction: Walking deficits and balance disorders are common problems in older people. In this study, we aimed to investigate the effect of age, gender and falling history on balance and walking speed.

Methods: The study included 249 patients in the geriatric rehabilitation unit, Department of Physiotherapy and Rehabilitation, Hacettepe University. Socio-demographic characteristics such as age, gender etc. were recorded. Functional balance was assessed by the functional reach test (FRT), single leg stance test (SLST), Berg Balance Scale (BBS) and walking speed assessed by Timed Up and Go Test (TUG). Individuals were divided into groups according to their age, sex and falling history.

Results: Participants were divided into 3 groups: young-old (n = 119), middle-old (n = 91) and oldest-old (n = 39). There was no significant difference between young and middle old individuals in TUG (p>0.05), but there was a significant decrease in TUG, FRT, SLST and BBS scores with aging (p<0.05). Significant differences were found in favor of men (female: 147, male:102) in terms of FRT, SLST and BBS scores (p<0.001). BBS scores were lower in the elderly who had fall history than elderly who had not fallen within the last year (p = 0.025).

Conclusion: In the end of the study, female gender and falling history affected walking speed and balance negatively in the older age. It is important that balance and gait disturbances that accompany the aging process must be decreased with appropriate exercise programs and fall prevention trainings to prevent falling.

Keywords: Walking, balance, falling, elderly

OP-38

SHOULD DIAGNOSTIC CRITERIA FOR METABOLIC SYNDROME CHANGE IN THE ELDERLY?

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Aım: Metabolic syndrome is an increasing public health problem with outcomes such as diabetes mellitus and cardiovascular disease. Organizations such as NCEP ATP-III, WHO, IDF and TEMD propose different diagnostic criteria for determining the metabolic syndrome. Various studies have shown that visceral fat measurement (VFM) is more valuable than anthropometric measurements in determining metabolic syndrome. Here, we aimed to determine whether the anthropometric methods used to describe the metabolic syndrome differ between old and young males.

Materıals and methods: 200 men who did not meet exclusion criteria (patients with poor overall condition, those with ascites, those who use drugs which affect fasting insulin measurement) participated in the study. According to the NCEP ATP-III criteria; 108 of these patients had metabolic syndrome while 92 of these had no metabolic syndrome. Patients were divided into two groups as old (≥65) and young (<65); and biochemical, anthropometric and visceral fat measurements were performed. VFM was measured by ultrasonography (Figure 1). The relationship between VFM and diagnostic criteria of metabolic syndrome was investigated by Pearson correlation analysis. The WC cut-off value of males was determined by ROC curve analysis.

Results: The mean age of the participants was 49.06 ± 15.26. There were no significant differences in diastolic blood pressure, weight, BMI, WC, HC, WHR, fasting blood glucose, satiety blood glucose, triglyceride(TG), HDL, LDL, HbA1c, hsCRP, fasting insulin, HOMA-IR, SFM and VFM values between two groups. Only systolic blood pressure and height were significantly different between two groups (Table 1). There was positive correlation with VFM and systolic blood pressure, diastolic blood pressure, fasting and satiety blood glucose, TG, WC, BMI; was negative correlation with HDL (table 2). When the anthropometric measurements were compared , the most valuable method was found as WC, BMI,WHR and HC in both groups, respectively; however the correlation between VFM and anthropometric measurements was stronger in young males (Table 3). The WC cut-off value of males was found to be 98.5 cm (75.2% sensitivity, 69.0% specifity).

Conclusıon: It is known that anthropometric measurements used to describe the metabolic syndrome change according to breeds. According to our study, WC measurement was found the most valuable measurement in determining metabolic syndrome, also men's WC cut-off value was found 98.5 cm and this was lower than NCEP ATP-III suggestion. In addition, the value of anthropometric measurements in the elderly were found to be lower than in young men. Based on these results, we concluded that the diagnostic criteria of metabolic syndrome should be redefined for Turkish men, especially for the elderly.

Keywords: Metabolic syndrome, visceral fat, anthropometric measurement, waist circumference

Figure 1. Visceral Fat Measurement by Ultrasonography

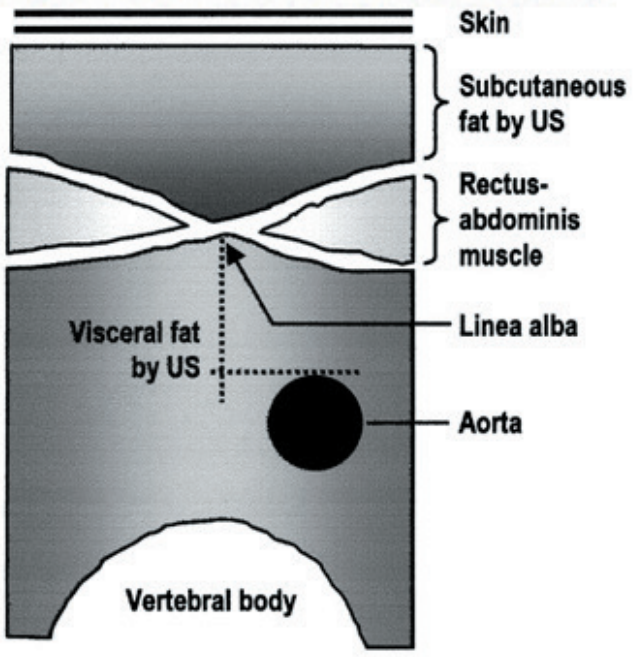

Table 1. Comparison of mean values of two groups

	Older Group (N:31)	*Young Group (N:169)*	*Total (N:200)*	
	Mean	*Mean*	*Mean*	*p Value*
Age	70.90±6.72	45.05±12.79	49.06±15.26	0.000(**)
Systolic Blood Pressure (mmHg)	148.42±25.00	132.10±23.11	134.63±24.08	0.000(**)
Diastolic Blood Pressure (mmHg)	84.87±12.15	85.92±15.76	85.76±15.23	Ns
Weight (cm)	167.94±5.15	171.71±7.01	171.13±6.88	0.005(*)
Height (kg)	80.00±10.21	82.82±15.40	82.38±14.73	Ns
Body Mass Index (kg/m^2)	28.37±3.47	28.10±4.98	28.14±4.77	Ns
Waist Circumference (cm)	99.87±9.77	96.59±13.35	97.10±12.90	Ns
Hip Circumference (cm)	92.94±6.20	91.55±8.95	91.77±8.58	Ns
Waist Hip Ratio	1.07±0.05	1.05±0.07	1.05±0.07	Ns
Fasting Blood Glucose (mg/dl)	129.84±61.40	121.01±58.82	122.38±59.16	Ns
Satiety Blood Glucose (mg/dl)	162.77±74.10	159.69±112.51	160.17±107.31	Ns
Triglyceride (mg/dl)	163.87±74.18	174.06±118.54	172.48±112.72	Ns
HDL Cholesterol (mg/dl)	45.00±9.54	44.94±8.32	44.95±8.49	Ns
LDL Cholesterol (mg/dl)	116.97±31.85	111.46±33.99	112.31±33.65	Ns
HbA1c (%)	6.85±1.68	6.59±2.03	6.63±1.98	Ns
hsCRP (mg/dl)	3.05±2.45	3.10±3.08	3.09±2.99	Ns
Fasting Insulin (uU/ml)	10.87±5.94	11.16±7.01	11.12±6.84	Ns
HOMA-IR	3.58±2.78	3.36±2.65	3.39±2.66	Ns
Subcutaneous Fat Measurement (mm)	13.44±4.67	13.78±6.33	13.73±6.09	Ns
Visceral Fat Measurement (mm)	61.81±22.68	57.63±23.65	58.28±23.49	Ns

Ns: not significant; *: p<0,05; **: p<0,01

Table 2. Correlation between visceral fat measurement and diagnostic criteria of metabolic syndrome

	Systolic Blood Pressure	*Diastolic Blood Pressure*	*Fasting Blood Glucose*	*Satiety Blood Glucose*	*Triglyceride*	*HDL Cholesterol*	*Waist Circumference*	*Body Mass Index*
Visceral Fat Measurement	0.347(**)	0.304(**)	0.176(*)	0.237(**)	0.262(**)	-0.170(*)	0.752(**)	0.698(**)
Pearson Correlation Significance	0.000	0.000	0.013	0.001	0.000	0.016	0.000	0.000
(2-tailed) N	200	200	200	200	200	200	200	200

Ns: not significant; ***:** p<0,05; ****:** p<0,01

Table 2. Correlation between visceral fat measurement and anthropometric measurements

		Body Mass Index	*Waist Circumference*	*Hip Circumference*	*Waist Hip Ratio*
Older Group	Visceral Fat Measurement	0.611(**)	0.659(**)	0.533(**)	0.542(**)
	Pearson Correlation Significance	0.000	0.000	0.002	0.002
	(2-tailed) N	31	31	31	31
Young Group	Visceral Fat Measurement	0.713(**)	0.766(**)	0.609(**)	0.639(**)
	Pearson Correlation Significance	0.000	0.000	0.000	0.000
	(2-tailed) N	169	169	169	169
Total	Visceral Fat Measurement	0.698(**)	0.752(**)	0.599(**)	0.628(**)
	Pearson Correlation Significance	0.000	0.000	0.000	0.000
	(2-tailed) N	200	200	200	200

Ns: not significant; ***:** p<0,05; ****:** p<0,01

OP-39

DISABILITY DISTRIBUTION OF GERIATRIC PATIENTS ATTENDING TO THE HEALTH BOARD IN A RURAL AREA IN 2016

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Objective: The purpose of this study is to determine the demographic and disability ratios and disability distribution of geriatric patients who applied in 2016 to an educational research hospital in a rural area to receive a health board report to benefit from disability rights.

Methods: The hospital archives were examined and the records of the persons who applied for the health board report were found.

Results: A total of 727 geriatric patients referred to the health board. 28 of them were referred to the referee center. Of the remaining 699 patients, 426 (60.9%) were female and 273 (39.1%) were male. The mean age of the participants was 77,62 ± 7,74 (min: 65 max: 104) (F: 78,07 ± 7,54 M: 76,93 ± 8,02). The average rate of disability calculated according to the "REGULATION ON HEALTH BOARD REPORTS TO BE GIVEN DISABILITY AND CLASSIFICATION " was 79,96 ± 17,79% (10-100). The average disability rate of females was 79.66 ± 17.61% and the average disability rate of males was 80.41 ± 18.24%. There was no statistically significant difference between the male and female groups in terms of the mean disability rate (p = 0.239). Of the 202 (28.9%) who were considered as severely disabled, 123 were female (28.9%) and 79 were male (28.9%). There was no statistically significant difference between male and female group with severe disability rates (p = 0,457). The number of patients with disabilities compared to organ systems and mean disability ratios are shown in Table-1. When the patients are separated as females and males, the percentage of patients with cardiovascular, endocrine and musculoskeletal disabilities are higher in females and the percentage of patients with urogenital, respiratory end oncological disabilities are higher in males (all p<0,05). But there is no statistically important difference between the mean disability ratios of these systems. The list of diseases that causing disability and their numbers are shown in Table-2.

Conclusion: The first three organ systems which causes disability in the patients included in the study are the cardiovascular system, the musculoskeletal system and the visual system. Osteoarthritis, hypertension and visual loss are the most common seen disorders for these systems among the study population.

Keywords: disability, geriatrics, health board

Table 1. Number of patients with disabilities compared to organ systems and mean disability ratios

Organ System	*N (total)*	*Female (N)*	*Male (N)*	*P*	*Total Disability Ratio (mean±SD) (All patients)*	*Female Total Disability Ratio (mean±SD)*	*Male Total Disability Ratio (mean±SD)*	*P*
Ear Nose Throat System	164 (%23,5)	92 (%21,6)	72 (%26,4)	0,087	19,09±11,39	18,98±11,25	19,22±11,64	0,910
Mental and Behavioral System	34 (%4,9)	17 (%4)	17 (%6,2)	0,123	46,65±19,72	43,82±21,18	49,47±18,36	0,290
Skin	2 (%0,3)	1 (%0,2)	1 (%0,4)	0,629	5±0	5±0	5±0	-
Hematopoietic System	-	-	-	-	-	-	-	-
Cardiovascular System	625 (%89,4)	393 (%92,3)	232 (%85)	0,002	39,48±22,82	38,05±21,56	41,92±24,66	0,125
Visual System	364 (%52,1)	216 (%50,7)	148 (%54,2)	0,204	37,67±25,89	38,76±26,37	36,09±25,17	0,399
Digestive System	5 (%0,7)	2 (%0,5)	3 (%1,1)	0,301	26,0±21,91	30,0±28,28	23,33±23,09	0,800
Urogenital System	228 (%32,6)	121 (%28,4)	107 (%39,2)	0,002	29,91±28,37	27,01±26,30	33,19±30,34	0,182
Endocrine System	183 (%26,2)	123 (%28,9)	60 (%22)	0,026	20,46±3,12	20,32±3,31	20,60±2,71	0,281
Respiratory System	98 (%14)	49 (%11,5)	49 (%17,9)	0,012	34,70±18,66	32,45±15,88	36,96±20,99	0,355
Burns	-	-	-	-	-	-	-	-
Oncological Diseases	34 (%4,9)	15 (%3,5)	19 (%7)	0,031	50,50±30,84	50,13±29,92	50,78±32,36	0,864
Nervous System	176 (%25,2)	111 (%26,1)	65 (%23,8)	0,282	41,54±21,86	41,37±21,73	41,83±22,22	0,987
Musculoskeletal System	553 (%79,1)	361 (%84,7)	192 (%70,3)	<0,001	39,52±21,73	39,95±21,41	38,70±22,35	0,413

Table 2. List of diseases that causing disability and their numbers

Organ System	*Disease (N)*
Ear Nose Throat System	Hearing loss: 163, deaf-dumb:1 permanent tracheostomy: 1
Mental and Behavioral System	Depressive disorder: 13, bipolar disorder: 2, anxiety disorder: 9, personality disorder: 2 psychotic disorder: 14, personality disorder: 5, posttraumatic stress disorder: 1, organic mental disorder: 5, mental retardation: 3
Skin	Decubitis ulcer:3
Cardiovascular System	Hypertension: 474, arrhythmia: 56, coronary artery disease: 226, heart failure: 163, pulmonary hypertension: 92, valve pathology: 440, cardiomyopathy: 1, permanent pacemaker: 2 peripheral arterial disease: 4, past deep venous trombosis:2
Visual System	Cataract: 211, visual loss: 255, senile macular degeneration: 47, optic atrophy: 20, glaucoma: 8, retinal detachment: 5, diabetic retinopathy: 25, corneal leukemia: 5
Digestive System	Cirrhosis: 3, opere inguinal herni: 2
Urogenital System	Chronic renal failure: 68, hemodialysis: 29, incontinence: 141, benign prostatic hyperplasia: 40, nephrectomy: 1, orchiectomy: 1, cystofix: 2, total abdominal hysterectomy and bilateral salpingoooferectomy: 2
Endocrine System	Diabetes mellitus type 2: 182, hypothyroidism: 8, obesity: 7, pitutary adenoma: 1, pitutary dwarfism: 1
Respiratory System	Chronic obstructive pulmonary disease: 87, asthma: 12, restrictive pulmonary disease: 12, obstructive sleep apnea: 2, past tuberculosis: 1
Oncological Diseases	Lung ca:7, thyroid ca: 1, colon ca: 9, rectum ca: 2, larynx ca: 1, lymphoma: 1, malign melanoma: 1, breast ca: : 1, ovarian ca: 1, prostate ca: 5, renal cell ca: 1, testis ca: 1
Nervous System	Cerebrovascular disease: 106, aphasia: 16, epilepsy: 11, Parkinson's disease: 40, dementia: 131, hereditary spastic paraparesis: 2, traumatic paraplegia: 1, traumatic tetraplegia: 2, myopathy: 1, poliomyelitis:4, cerebral palsy:2, peripheral facial paralysis: 1, neuropathic pain: 8
Musculoskeletal System	Osteoarthritis (hip / knee / vertebral / hand): 557, opere discopathy / spondylolisthesis: 24, endoprosthesis (hip / knee): 64, amputation: 20, rheumatoid arthritis: 7, congenital joint deformity: 1, traumatic vertebral fracture: 7 , past upper extremity fracture: 10 past lower extremity fracture: 47

OP-40

PREVALENCE OF ABUSE AND NEGLECT, AND ASSOCIATED FACTORS IN COMMUNITY DWELLING OLDER ADULTS

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Objective: Elder abuse and neglect is a-critical-health-care-issue-that-must-be-brought-to-the-attention-of-health-care-providers-and-older-adults' family-members.Each-year-approximately-10%-of-adults-65-years-and-older-are-abused. Elder abuse and neglect has plagued society for centuries but only recently has the issue come to the attention of health care providers, law enforcement agencies, and protective services.In this study, we aimed to assess the prevalence of elder abuse and neglect, and associated factors in a Geriatrics outpatient clinic.

Methods: We included the elders >=60 years of age admitted to outpatient clinic on their first admission in 1 year period. Patients with acute clinical conditions (acute myocardial enfarction, cerebrovascular accident, systemic infection, bereavement period etc), disable to cooperate, excessive edema which prevents to have sufficient bioimpedance analysis, and absence of informed consent were excluded. Eligible individuals had face to face interview by social worker in a room and alone. Demographic data, components of comprehensive geriatric assessment (CGA), The Hwalek-Sengstock Elder Abuse Screening Test (HSEAST) scores have been recorded. Also a new scale has been developed by our social worker to assess elder's self neglect. The cut-off threshold for new self-neglect scale was calculated from ROC analyses using cut-off values that predicted social workers opinion whether the elder has neglect.

Results: 226 eligible individuals were included among 481 new admission.142 were female (%63) and 84 were male (%37). Mean age was 74±6.5 years. 56% were married, 2,7% were single, 2,7% were divorced, 38,7% were widower. 20,4% were living alone, 31,4% were living with spouse, 21,7% were living with a child or grandchild. 15% of individuals speculate that they have been neglected or abused. 82,7% of total individuals speculate that they don't know what to do in case of neglect or abuse. HSEAST scores revealed that 81 (35,8%) respondents met the criteria for elder abuse/neglect risk. This ratio were higher in female group than male group (p=0,008; 42% and 25%, respectively). HSEAST scores were positively correlated with geriatric depression scale scores and negatively correlated with EQ5D self-report quality of life questionnaire (p<0,0001 for both).The cut-off threshold for new self-neglect scale was 7. The new self-neglect scale scores were negatively correlated with HSEAST scores, geriatric depression scale scores and EQ5D scores (p=0,11, p<0,0001, p=0,001 respectively)

Conclusion: We observed high prevalence rates of abuse/neglect. This study showed females are at more abused risk than males. Abuse and neglect are correlated with lower quality of life and depression. Also our new self-neglect scale was correlated with HSEAST scores, depression, and lower quality of life. This cross-sectional study confirms that elder abuse is a considerable public health problem warranting further longitudinal studies.

Keywords: elder abuse, neglect

OP-41

THE ATTITUDES OF GERONTOLOGY, ELDERLY CARE AND HEALTH VOCATIONAL SCHOOL STUDENTS TOWARDS ELDERLY DISCRIMINATION

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Background: Old age is generally defined as a social phenomenon accompanied by prejudices, stereotypes and negative images. Despite the arguement that in recent years a social process of positive change is taking place in the perception of the elderly, the negative image is still the most frequent among all age groups, including the young people

Objective: The aim of this study was to determine the attitudes of gerontology, elderly care and health vocational school students towards elderly discrimination.

Method: The study was conducted with 790 students in academic year 2014/2015. Questionnaire form and 'Ageism Attitude Scale' information form were used as data collection instruments. In the question form, there were questions about sociodemographic characteristics of the students, the concept of old age and thoughts about life with the elderly also questions about whether or not they would like to work with elderly individuals when they graduate. Permission to conduct this research was obtained from the ethics committee of the university as a written document. Likewise, the research data were collected after receiving informed written consent from the students included in the study. The analyses of the data were obtained by us-

ing descriptive statistical, students t test, Mann-Whitney U and ANOVA analyzes in SPSS 23.0

Results: Of the students 28.1% were male and 71.9% were female, the majority of students were single. It was found out that students have positive attitudes towards elderly discrimination and significant differance was found between ageism attitude scale scores of students and their gender, class and academic programme ($p<0.005$).

Conclusion: It is necessary to raise awareness in the educational process of the students who will provide services for the aging in the future as the service personnel require special level of consciousness and equipment.

Keywords: Aged, attitude, ageism.

OP-42

THE EVALUATION OF IRON DEFICIENCY AND IRON DEFICIENCY ANEMIA TREATMENT WİTH COMPREHENSİVE GERİATRİC ASSESMENT

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Introduction : Meaning of functionality in elderly; physical and cognitive performance is enough to make daily life activities independent [1].Detection of negative findings with comprehensive geriatric assesment (CGA) and, treatment are the most important goals of geriatric science.One of the factors affecting functionality and CGA in the elderly is anemia. İron deficiency has a negative impact on functionality, especially cognitive status, in the elderly. However, observational studies evaluating outcome of treatment are absent except for a few studies in the cancer patients[2].The aim of our study was to investigate the effect of iron deficiency or iron deficiency anemia treatment on physical and cognitive functions assessed by CGA in elderly patients.

Method: The study included 83 patients whose iron deficiency and iron deficiency anemia were detected. Patients with secondary diseases (such as MMT <10 dementia) were excluded, which would have an obvious negative effect on CGA. Katz was used to basic living activities, Lawton-brody (LB) for assess daily instrumental life activities, mini-nutritional evaluation for nutritional evaluation, hand grip strength (HGS) and walking speed for muscle strength assessment, and mini-mental evaluation for cognitive status.At the 0th and 6th months the CGA tests were performed and the iron parameters were checked. Iron replacement was performed either orally or parenterally according to the target hemoglobin

Results: The demographics of patients is shown in Table 1. The gastrointestinal system results are summarized in Table-2.Compared with the Wilcoxon sign rank test, the pre- and post-iron values of the patients were found to be significantly different in all values except for the Katz in the comparative values. The results are summarized in Table 3.It was found that walking speed groups before and after iron reinforcement improved significantly. (Chi-square: 25.037, p value: 000)

Discussion: In our study, iron treatment in the anemia of iron deficiency and iron deficiency in the elderly were shown to improve in the tests evaluating the functionality. It was found that the iron replacement therapy improved MMT, LB, MNA score, HGS and walking speed. It was also found that hemoglobin, iron, total iron binding capacity, transferrin saturation and ferritin values were improved. It has been found that iron replacement in geriatric patients improves nutritional, functional independence and cognitive functions from the greatest problems of geriatric patients. The underlying cause of the disease must be investigated. Regardless of the underlying cause, iron should be replenished at an adequate dose and time, and patients should be checked regularly to assess treatment response and patient compliance. In cases such as additional disease, nutritional deficiency, cognitive impairment that can be detected in geriatric patients, it is absolutely necessary to perform CGA and to treat the determined conditions if possible.

Keywords: iron deficiency and iron deficiency anemia treatment effect, elderly, comprehensive geriatric assesment

Table 1. Demographic Information of Patients

Average Age	76.8 ± 7.2818
Female	% 69.1
Male	%30.9
Polypharmcy (≥ 5 Drugs)	% 66.7
Diabetes Mellitus	% 48.1
Hypertension	% 90.1
Hyperlipidemia	% 70.4
Chronic Obstructive Pulmonary Disease	% 29.6
Thyroid Diseases	% 17.3
Chronic Kidney Disease	% 14.8
Cerebrovascular Event-Neurological Disease	% 21.3
Atrial Fibrillation	%13.6
Chronic Liver Disease	%3.7
Atherosclerotic Heart Disease - Heart Failure	% 49.4
Autoimmune Diseases	% 4.9
Malignancy	% 9.9
Parkinson	% 11.1
Depression	% 30.9
Fall	% 21
Osteoporosis	% 44.4
Urinary Incontinence	% 55.6
Use Of Antiagregants	% 59.3
Use Of Anticoagulants	% 21
Dual Therapy	% 19.8

Table 2. Pathologic findings of endoscopy and colonoscopy

	%
Stomach Ulcer	6.4
Stomach Polyp	10.4
Gıs Malignity	8.5
Intestinal Polyp	21.3
Colonic diverticul	10.6
Celiac Disease	8.5
Inflammatory Bowel Diseases	2.1
Other Causes Of Malabsorption*	27.7
Esophageal Varices Bleeding	4.3

*Other causes of malabsorbtion include; Helicobacter pylori infection, pangastritis, atrophic gastritis, bariatric surgery or GIS surgery.

Table 3. Comparison of Pre-Treatment and Post-Treatment Tests (with Wilcoxon Test)

	Pre-treatment Median Value (0. month)	*After treatment Median Value (6. month) (Second evaluation)*	*Z value*	*p value*
Katz Score	6	6	-0.053[1]	,958
Lawton-Brody Score	8	15	-4.730[1]	,000
MNA	9	12	-3.186[1]	,001
Hand Grip Strenght	17.9	19.9	- 4.291[1]	,000
MMT	26	28	- 5.225[1]	,000
Hemoglobin (g/dL)	10.5	12.3	- 6.379[1]	,000
Demir (µg/dL)	32	65	-7.324[1]	,000
TIBC (Total Iron Binding Capacity) (µg/dL)	412	328	- 6.569[2]	,000
Transferrin Saturation (%)	8	18	-7.278[1]	,000
Ferritin (ng/mL)	12.1	78.2	- 7.166[1]	,000

[1]: based on negative ratios; [2]: based on positive ratios

OP-43

COMPARISON OF CORNEAL ENDOTHELIAL CHANGES AFTER INTRAVITREAL INJECTION OF AFLIBERSEPT IN ELDERLY EYES

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Objective: Patients with exudative senil macular degeneration (SMD) often receive multiple intraocular injections of anti-VEGF medications. The objective of this study was to evaluate the effects of repeated intravitreal aflibersept injections on corneal endothelium in elderly eyes.

Materials and methods: Thirty-eight eyes of 38 patıents who had received consecutive 3 months intravitreal aflibercept injections (0.5 mg/0.05 ml) for the treatment of SMD and 39 eyes of 39 healthy subjects were included in the study.The endothelial cell density(CD), coefficient of variation of cell size(CV), and percentage of hexagonal cells (Hexa) were analyzed and the central corneal thickness(CCT) was measured using noncontact specular microscopy. Data obtained from the aflibersept-injected eyes were compared with the eyes of the healthy control subjects. A comparison of endothelial properties was conducted between age-based groups: 65-75 years (grup 1), 75-85 years (grup2).

Results: According to the control group in the eyes with aflibercept, there was no significant difference in the coefficient of variation (CV), hexagonality (Hexa), central corneal thickness(CCT) in both group. (p>0.05 for all).Mean cell density (CD) in grup 1 was statistically significantly lower in eyes with aflibersept (2370.78 cells / mm^2) than control (2625.21 cells / mm^2) (p = 0.001). There was no statistically significant difference between aflibercept-injected eyes (2210.05 cells / mm^2) and control subjects (2282.09 cells / mm^2) in the mean CD of group 2 (p=0.58).

Conclusion: İn our study, corneal cell counts were decreased in eyes with intravitreal aflibersept between 65-75 years old.Corneal endothelial cell density decreases with age. A longer follow-up is required to determine long-term effects of anti-VEGF on corneal endothelial density and morphology in elderly patitent.

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Keywords: Corneal endothelium, elderly eyes

OP-44

ASSESSMENT OF AWARENESS OF CANCER SCREENING AND VACCINATION IN PATIENTS ADMITTED TO GERIATRIC OUTPATIENT CLINIC

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Introduction: Preventive medicine including cancer screening and vaccination is important for improving quality of life and decreasing morbidity and mortality in geriatric patients as well as in all age groups. The aim of this study is to evaluate the awareness of cancer screening and vaccination of the geriatric patients.

Material and methods: Patients aged 65 years or older, admitted to the geriatric outpatient clinic, were included in this study. Demographic characteristics of the patients were recorded. Two questionnaires assessing awareness of cancer screening and vaccination were applied to the patients consequently. Answers were recorded and SPSS 16 version was used for the statistical analysis.

Results: A total of 111 patients were included in this study. Median age was 72 years (min-max: 65-87) and %56.8 of them were female. Of all patients, 83.6% had knowledge about adult vaccination, however, vaccination rate at least one kind of vaccine were 48.2%. Influenza was the most known and applied vaccine (59% and 39.1%, respectively). Adult vaccination had never been recommended to 54.1% of the patients before. When asked to the patients "is vaccination useful or harmful for older adults?" Those answering "Useful" to this question were as 79%. Of all patients, 64.9% had knowledge about cancer screening and 37.8% of the patients learned from television, 18.2% of them from doctors and 23.2% from their relatives or neighbors. The three most common cancers known to be screened were lung, breast, and bowel (38.2%, 34.5% and 22%, respectively). When asked to the patients "have you ever been screened for cancer?" 30% of the patients answered "Yes". However, the rate of applying at least one type of cancer screening tool in medical history was 51.4% of the patients. Three most commonly performed screening tools were mammography, pap-smear and fecal occult blood test (32.1%, 22.9% and 22%, respectively). While 90% of the patients thought that cancer screening was required and useful, 1.8% thought it was unnecessary and useless.

Conclusion: It was shown in this study that vast majority of the patients declared they had knowledge about adult vaccination and cancer screening, but the rates of implementation of these preventive medicine applications were lower than expected. It is important to try to increase the implementation of preventive medicine in clinical practice.

Keywords: vaccination, cancer screening

OP-45

SARCOPENIA IN CHRONIC HEMODIALYSIS PATIENTS

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Aim: The porpuse of this study is to evaluate the prevalence of sarcopenia and the relationship between antropometric measurements and sarcopenia in chronic hemodialysis patients.

Method: 90 patients were taken into consideration in the study was performed during 3 months of 2016, in chronic hemodialysis patients. To assess muscle mass, bioimpedance analyses after 2 hours of hemodialysis, handgrapping for muscle strength and gait speed for physical performance were used. The patients were grouped as normal and according to the diagnostic criteria for EWGSOP (presarcopenic, sarcopenic, severe sarcopenic). Age, gender, weight, height, BMI, calfcircumference, muscle mass of the patients included in the study have been surveyed.

Result: Mean age of 80 patients was 55.71±14.45 (min: 18, max: 85), 56 (70%) men, 24 (30%) women. The prevalence of presarcopenia was 11 (13.8%), sarcopenia was 11 (13.8%) and only a 64 year-old man was severe sarcopenia. The etiology of renal failure were as follows: diabetes mellitus 30 (37%), hypertension 19 (24%), unknown etiology 18 (22%), glomerulonephritis 7 (9%) and amyloidosis secondary to FMF 6 (8%) patients. Young group (< 65 years; mean age: 49.3±11.1) were containing 7 (11.5%) presarcopenia, 8 (13.1%) sarcopenia and one severe sarcopenia. Geriatric group (≥ 65 years; mean age: 72.3±6.8) were containing 4 (21.1%) presarcopenia, 3 (15.8%) sarcopenia. Antropometric measurements of young patients were weight: 71.2±16.1 kg, body mass index (BMI): 26±5.2 kg/m^2, upper middle arm circumference: 27.6±4.4 cm, calf circumference: 35±3.5 cm, handgrip strength: 25.8±9.9 kg, freefatmassindex (FFMI): 18.1±2.6 kg/m^2, gait speed: 0.8±0.2 m/sec; whereas these results for geriatric group were weight: 69.1±12.6 kg, BMI: 28.6±5.4 kg/m^2, upper middle arm circumference: 27±3.5 cm, calf circumference: 32.7±3.2 cm, handgrip strength: 21.5±11.5 kg, FFMI: 16.2±3.2 kg/m^2. Calf circumference and FFMI in geriatric group was low and it was statistically significant (p: 0.001, p: 0.001). A significant difference was not observed between presarcopenia and sarcopenia groups when patients were compared in terms of geriatric and young or gender. Anthropometric measurements are as in table1 for sarcopenic and non-sarcopenic patients. When multiple regression analysis was conducted, it has been observed that anthropometric measurements are not significant. Mean of dialysis vintage was 3.9±3.7 (min: 1, max: 16) years. Average dialysis vintage for sarcopenic and nonsarcopenic patients were 5.3±4 years and 3.3±3.7 years respectively and statistically it was significant (p: 0.03). there were no statistical significance avaliable by groups and gender.

Conclusion: As in geriatric patients, sarcopenia is a real public health burden in hemodialysis patients as well. Rise was observed in frequency of sarcopenia when dialysis vintage increases. In order anthropometric measurements be more indicative for diagnosis of sarcopenia, it is necessary to indentify social cut-offs in new studies.

Keywords: geriatri, dialysis, sarcopenia

Table 1. The anthropometric measurements of groups

	Sarcopenia (-)	*Sarcopenia (+)*
Age	56.1±11.6	54.7±19.8
Gender (M/F)	34/22 (60.7/39.3 %)	22/2 (91.7/8.3 %)
BMI (kg/m2)	28.9±4.7	21.6±2.8
Weight (kg)	76.1±14.4	57.7±6.7
FFMI (kg/m2)	18.6±2.3	15.4±1.3
Bodyleanmass (kg)	49.8±12.1	41.8±7
Handgrip strength (kg)	24.8±11.2	24.2±8.2
Gait speed (m/s)	0.7±0.2	0.8±0.2
Upper middle arm circumference (cm)	29±3.8	24±2.5
Calf circumference (cm)	35.7± 3.5	31.6±1.7

OP-46

THE EFFECT OF EXERCISE TRAINING ON FOOT SENSORY, BALANCE AND FEAR OF FALLING IN FRAIL ELDERLY

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Introduction: Fraity is an important geriatric syndrome characterized by unintentional weight loss, fatigue, muscle weakness, decreased walking speed and physical activity. It leads to significant health problems such as hospitalization, deterioration in daily living activities, falls and decreased mobility. The aim of the study to investigate the effect of exercise training on foot sensory, balance and fear of falling in frail elderly.

Methods: In our study included that 48 frail elderly. Their Mini Mental State Examination Test scores' is 24 and above. Subjects were divided into three groups as control group (free exercise training), low intensity (40% of 1RM) and high intensity (70% of 1RM). Exercise training program included strengthening, balance and flexibility was applied 40-50 minutes a day, three times a week for 8 weeks with a physiotherapist. Socio-demographic information, cognitive function (Mini Mental State Examination), foot sensory (Monofilament Test), balance (Timed and Up Go, Berg Balance Scale) and fear of falling (The Fall Efficacy Scale) were recorded in the baseline and eighth week of the study.

Results: Mean ages of the control group, low and high intensity exercise groups were respectively 85.4±4.7, 84.5±4.8, 84.2±6.9 years. After the exercise training program, comparing the exercise groups with each other, there were no statistically difference in Monofilament Test (p=0.332), Timed Up and Go Test (p=0,692), Berg balance Scale (p=0,862) and The Fall Efficacy Scale (p=0.721).

Conclusion: In our study, as a result of exercise training, it was recorded that fear of falling, balance and sensory disorders which were often seen in frail elderly reduced comparing to control group. Both intensity exercise training had similar positive effect to recovery balance and sensory in frail elderly. Also fear of falling is reduced at the same time. In the clinic, Low intensity exercise training can be preferred because of the more reliable and it leads to less fatique in frail elderly.

Keywords: Frailty, exercise, elderly

OP-47

MUSCLE MASS ADJUSTED FOR BODY MASS INDEX REVEALS BETTER EFFICACY IN RELATION OF SARCOPENIA WITH FUNCTIONAL MEASURES

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Objective: The low musclemass (LMM) definition differsamong the consensus groups in terms of adjustment methods. Some authors suggest to adjust skeletal musclemass (SMM) by height while some others by weightor body massindex (BMI). The prevalence of sarcopenia differsaccordingtoitsadopteddefinition. Moreover, theassociation of sarcopenia with the adverse health outcomes also differamongdifferent definitions. Hereby, we aimed to examine which LMM adjustmentmethod revealsbetterefficacy in relationtoits functional outcomes.

MaterialsandMethods: Community-dwelling older adults 60-99 years of age were included. Body composition was assessed with bioimpedance analysis (BIA).LMM was evaluated according to our national data [SMMindex (SMMI)byheight: females<7.4 kg/m2,-males<9.2 kg/m2; SMMI byweight: females<%33.6, males<%37.4, SMMI byBMIa: females<0.82 males<1.05; byBMIb: females<0.68 kg/BMI males<1.02 kg/BMI]. Muscle strength was assessed by measuring hand grip strength with a Jamar hydraulic hand dynamometer. The relation of SMMI with hand grip strength, usual gait speed (UGS), activities of daily living (ADL), instrumental ADL (IADL) and frailty were examined between different adjustment methods.

Results:1307olderadults(421male, 886female)wereincluded. Theprevalences of LMM were2.1%, 47.2%, 63.4%and 21% withadjustmentsbyheight (H), weight (W), BMIaandBMIb, respectively. 39.4% had low grip strengthand36.1% had low UGS with a total of 54.5% lowmuscleperformance. Prevalences of sarcopenia were1.3%, 23.9%, 35.2%and 13.2% withadjustmentsbyheight, weight, BMIaandBMIb, respectively. Hand grip strengthwascorrelatedwithallSMMIs, mostbeingadjustedwiththe BMI (H, r=0.286; W, r=0.298;BMI, r=0.548, p<0.001). UGS was not correlatedwith LMM adjustedby H (p=0.267) but with W (r=0.077, p=0.009)and BMI (r=0.223, p<0.001). ADL was not correlatedwith LMM adjustedby H (p=0.71) but with W (r= 0.08, p=0.008)and BMI (r=0.17, p<0.001). IADLwas not correlatedwith LMM adjustedby H (p=0.49) but with W (r= -0.059, p=0.045)and BMI (r=0.066, p=0.026) (Table 1).

The LMM by H wasonlyrelatedto ADL (p=0.002) and LMM by W wasonlyrelatedto HGS (p<0.001). LMM byBMIaandBMIbwererelatedtoall of thefunctionalmeasures (HGS, UGS, ADL, IADL, frailty) verysignificantly(p<0.001forall) (Table 2).

Conclusions: Theprevalences of LMM and sarcopenia changesignificantlybetween SMM adjustmentmethods. Musclemassadjustmentwith BMI provesbetterrelationwithfunctionalassociations of sarcopenia.

Keywords: sarcopenia, functionality, BMI

Tablo 1 Farklı SMMI indeksleri ile fonksiyonel parametreler arasındaki ilişki

SMMI düzeltme yöntemi	Boy (kg/m²)	kilo (%)	VKI
Yaş	p=0.007	p=0.001	p=0.02
	r=-0.075	r=0.221*	r=0.056
VKI	p<0.001	p<0.001	p<0.001
	r=0.628	r=-0.752*	r=-0.633
El sıkma gücü	p<0.001	p<0.001	p<0.001
	r=0.286	r=0.298	r=0.548*
Yürüme hızı	p=0.267	p=0.009	p<0.001*
	r=0.033	r=0.077	r=0.223
ADL	p=0.71	p=0.008	p<0.001*
		r= 0.08	r=0.17
IADL	p=0.49	p=0.045	p=0.026*
		r= -0.059	r=0.066

LMM: Düşük kas kütlesi,SMMI: İskelet kas kütlesi indeksi,BMI: Vücut kütle indeksi,ADL: Günlük yaşam aktiviteleri,IADL: Aletli günlük yaşam aktiviteleri

Tablo 2. Farklı düzeltme yöntemleri ile LMM ile fonksiyonel parametreler arası ilişki.

LMM düzeltme yöntemi	Boy	kilo	VKIa	VKIb
El sıkma gücü	p=0.3	p<0.001	p<0.001	p<0.001
		(27.8 vs20.6)	(29 vs 20.5)	(26.7 vs22.3)
Yürüme hızı	p=0.4	p=0.16	p<0.001*	p<0.001
			(1 vs 0.64)	(0.91 vs 0.66)
ADL	p=0.002	p=0.78	p<0.001	p<0.001
	(17.2 vs16.1)		(17.4 vs 16.8)	(17.3 vs 16.7)
IADL	p=0.22	p=0.08	p<0.001	p<0.001
			(21.7 vs18.8)	(21.1 vs 18.5)
kırılganlık*	p=0.106	p=0.51	p<0.001	p<0.001
			(0.8 vs1.6)	(1 vs 1.6)

*: FRAIL skorlaması ile değerlendirildi

ADL: Günlük yaşam aktiviteleri

IADL: Aletli günlük yaşam aktiviteleri

OP-48

PHYSIOTHERAPY TO IMPROVE PHYSICAL ACTIVITY IN AN ELDERLY INPATIENT

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Background: In inpatient older adults, decrement in their mobility and loss in their physical activity are seen in time line between their hospitalization and discharge. Bed rest and inactivity in hospital are detrimental for mobility and function. The aim of our study was to investigate the effect of physiotherapy and rehabilitation program on physical activity, functional skills and quality of life in elderly inpatient.

Method : A total of 124 patients (mean age: 74,7± 6,5) participated in this study. A total of patients randomized as study and control group. Patients were admitted to between November 2015 and April 2016. All patient had an expected length of stay 5 or more days. Assessment for cognitive function (Mini Mental State Test), comorbidity (Charlson Comorbidity İndex), physical activity (Physical Activity in İnpatient Rehabilitation-PAIR), functional mobility (De Morton Mobility Index), activities of daily living (Katz Index of Independence in Activities of Daily Living), quality of life (EuroQol-5D) were used at admission and discharge in hospital. Thirty minutes hospital based physiotherapy and rehabilitation program including breathing exer-

cises, balance, coordination and strengthening exercises were performed by intervention group under supervision physiotherapist in hospital. Control group received usual care and they did not take physiotherapy and rehabilitation. Length of stay in hospital of all participants was recorded.

Results: The groups were similar in sociodemographical feature and comorbidity. Sixty two patients are randomly assigned to the each group. Increments in functional mobility ability, quality of life and improvement in the daily questioned physical activity levels were found in the study group that received physiotherapy ($p<0.05$). There were no significant difference in length of stay between intervention and control groups.

Conclusion: These results reveal the necessity of physiotherapy and rehabilitation program to prevent negative effects of the hospitalization process of the geriatric patients who have acute and multiple medical problems.

Keywords: mobility limitation, exercises therapy, rehabilitation, quality of life

TABLE I. Results of the 3 primary outcome measures at admission and disharge for the two groups

		X± SD Admission	X± SD Discharge	p
DEMI	Intervention Group	50,64±20,59	57,82±22,35	0,000*
	Control Group	47,91±22,01	48,56±21,72	0,346
Katz ADL	Intervention Group	14,30±3,13	15,98±2,91	0,001*
	Control Group	14,35±2,42	14,61±2,44	0,769
EQ-5D	Intervention Group	9,87±4,74	9,58±4,65	0,019*
	Control Group	9,50±2,24	9,51±2,17	0,776

X±SD : Mean ± Standart Deviations, DEMI : De Morton Mobility Index, PAIR: Physical Activity inpatient Rehabilitation
KATZ : The Katz Index of Independence in Activities of Daily Living , EQ5D : The EuroQol
*p<0,005

OP-49

THE FREQUENCY, BİOLOGİCAL SOCİAL ETİOLOGY OF BALANCE DİSORDER İN THE ELDERLY AND İT'S ROLE İN FALLİNG RİSK

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Purpose: Balance disorder is one of the most important risk factors leading to falls in the elderly. Falls are important geriatric problems which can cause fracture, disability and additional need for care as well as they may increase mortality and morbidity. The purpose of the present study was to determine the frequency, biological and social etiology of balance disorders and their role in falling risk in the elderly.

Materials and Methods: The study design was cross-sectional. Study group included individuals over 65 years of age residing at the center of Aydın/Söke. A total of 639 elderly person with a mean age of 73,99±6,6 who were selected by stratified random sampling were enrolled. The study was performed as face to face survey study at home of the elderly. Sociodemographic, biological and social data of the elderly was obtained by 'Elderly Introduction Form'. Balance disorder was determined by use of 'Berg Balance Scale' (BBS). 'Fall Evaluation Form' was applied to subjects who already had a fall history. Statistical evaluations were performed by Chi-Square Test, Fisher's Exact Test, t Test and Logistic Regression Analysis in SPSS.

Results: In this study frequency of balance disorder was determined 34,6% in community-dwelling elderly. The mean of BBS score was determined as 43,49. Frequency of falls in the previous year was determined as 39,1%. Older age (p<0.001), female sex (<0.001), presence of defect of vision (=0.001), presence of impaired walking (<0.001), increase in the number of chronic disease (<0.001), increase in the number of drugs used (<0.001), presence of incontinans and nocturia (<0.001), not walking regularly (<0.001), loneliness (<0.001), absence of free time activity (<0.001) were determined to be the factors which increase the balance disorder frequency. Frequency of balance disorder was observed more in elderly who had a history of falls compared to elderly with no-falls (<0.001).

Conclusion: As shown in our study, balance disorder is seen commonly in the elderly and may be triggered by a variety of biological and social factors. It is an important geriatric problem as it causes falls which increase the morbidity and mortality in this age group. Thus, it is crucial to develop and implement national health and social policies to eliminate the causes of this problem as well as to prioritize preventive health services in the elderly population which increases everyday.

Keywords: Elderly; balance disorder; biological situation; social activity; falls

Tablo 1. Relationship between falling history and balance disorder

	n	Balance Disorder n (%)	p
Fall History (n=639)			<0,001* - <0,001**
No	389	95 (%24,4)	
Yes	250	126 (%50,4)	

OP-50

THE COMPARISON OF RISK OF FALLS IN HOSPITALIZED ELDERLY AND YOUNGER PATIENTS

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Objective: Falls are quite frequent at the hospitals and they adversely affect patient safety (Ang, Mordiffi, Wong, Devi and Evans 2007). Falls cause injuries and loss of function in individuals, leading to a prolonged hospital stay, increased costs, and reduced quality of life. This study aims to evaluate and compare the risks and causes of falling in hospitalized patients over 65, and <65 years of age.

Methods: A total of 250 patients in the internal medicine clinic were evaluated retrospectively, between January 2015 and April 2015. Forty-five patients were excluded from the study, because of death. The sociodemographic data of 205 patients, the risk scores of fall at admission and discharge, chronic diseases and medications were recorded. Patients were divided into two groups according to the age of 65. The SPSS 20 package program was used for statistical analysis.

Results: Of the 205 patients, 45% (n = 93) were <65 years, 55% (n = 112) were over 65 years of age. The length of stay was 6 days inthe younger group and 8 days in the group of ≥65 years. The mean age was 46.76 ± 10.92 years for <65 years and 77.17 ± 7.54 years for ≥65 years of age. In the <65 group; 45% was women , 55% men. In the elderly group 52% were women, and 48% were men. No statistically significant differences were found between the risk scores at admission and discharge between the groups. Risk scores at hospitalization and discharge were significantly higher in patients with ≥65 age group (p = 0.04, p = 0.006). Patients with hypertension in the ≥ 65 age group (p=0.032), and diabetes mellitus in the younger group had statistically significant higher fall risks (p = 0.032). There was no significant difference between the two groups in terms of heart disease, arthritis, depression, renal insufficiency, anemia, malignancy and cerebrovascular diseases. As the number of chronic diseases increased, the risk of falls in group <65 years was significantly higher than the other group (p = 0.007). There was no significant difference between the age groups on the risk of falling in terms of most of the drugs at risk (psychotropic drugs, sedative hypnotic group drugs, anti-

psychotics etc) The risk of falls in the age group <65 years was higher (p = 0.032) with anticoagulants and higher in the group ≥65 years (p = 0.02) with narcotic analgesic usage. As the number of the risky medications, and the total number of medications are increased , the risk of falls in the <65 years group increase significantly compared to the other group (P= 0.001) (p = 0.001), respectively.

Conclusion: All hospitalized patients are at high risk for falls, especially the elderly. Increased number of risky medications and increase in the total number of medications increase the risk of falls. Therefore, the patients who are hospitalized should be followed regularly and the necessary precautions in terms of the risk of falling should be taken.

Keywords: risk of falls, hospitalized patients, elderly

OP-51

STUDY OF OSTEOPOROTIC FRACTURES (SOF) FRAILTY INDEX: A USEFUL ADD ON FOR LONESOME GERIATRICIANS?

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Objective: Frailty has many unfavorable consequences. Identifying frailty among older adults is of the utmost importance since frailty can change clinician decisions about diagnostic and therapeutic interventions. As the only geriatrician in a tertiary care center, testing Study of Osteporotic Fractures (SOF) index for frailty screening and exploring the associated conditions were aimed.

Methods: Medical records of 310 older outpatients (from June 2016 to February 2017) were retrospectively reviewed. Demographic properties, comprehensive geriatric assessment (CGA) scores, laboratory results, and SOF index for 223 patients were examined. Three deficits (weight loss, physical strength, and exhaustion) are assessed with SOF index. Patients without any deficits were labeled as "robust" while patients with only one deficit were assigned to "pre-frail" group. Two or three deficits in a patient were considered as frailty.

Results: Among the recorded parameters advanced age (p=0.002), low KATZ score (p<0.001), low Lawton Brody score (p<0.001), low height (p<0.001), low weight (p=0.01), low MNA-SF (Mini Nutritional Assessment-Short Form) score (p<0.001), high TUG (Timed Up and Go test) duration (p<0.001), high Yesavage GDS (Geriatric Depression Scale) score (p<0.001), low MMSE (Mini Mental State Examination) score (p<0.001), low Hb concentration (p=0.014), elevated ESR (Erytrocyte sedimentation rate) (p=0.004), hypoalbuminemia (p=0.011), female gender (p<0.001), living without a spouse (p=0.049), five years or less duration of education (p=0.008), cerebrovascular accident (p=0.014), Parkinson's disease (p=0.012), absent history of alcohol intake (p<0.001), having difficulty about sleeping (0.021), needing walking aids (p<0.001), any type of urinary incontinence (p=0.018); being unable to bathe and dress (p<0.001), use toilet (p=0.001), transfer (p<0.001), feed oneself (p=0.029), and presence of malnutrition according to MNA-SF or ESPEN (The European society for Clinical Nutrition and Metabolism) criteria (p<0.001 for both) were all found to be associated with SOF defined frailty. In the multivariate analysis, Parkinson's disease (OR: 34.18 95% C.I 1.43-812.2 p=0.029), any type of urinary incontinence (OR: 3.43 95% C.I 1.01-11.62 p=0.047), high TUG duration (OR: 1.11 95% C.I 1.05-1.18 p<0.001), low MMSE score (OR: 0.80 95% C.I 0.70-0.92 p=0.002), elevated ESR (OR: 1.04 95% C.I 1-1.08 p=0.014), malnutrition according to ESPEN criteria (OR: 26.50 95% C.I 1.48-473.52 p=0.026) were all independently associated with SOF defined frailty.

Conclusions: SOF frailty index may be a useful adjunct to standard CGA since it takes about 5 minutes to apply.

Keywords: frailty, older, nutritional status, depression, dementia, activities of daily living

OP-52

ASSESSMENT OF FALL INCIDENTS IN THE NURSING HOMES; A CASE STUDY

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Aim: Falling is a common geriatric syndrome which substantially increases instances of death and sicknesses among the elderly. This topic should be medically and economically analyzed as it profoundly affects the standard of living of the elderly. Consequently, it is important to prevent falling.

Method: In this study, we have analyzed information from 97 elderly residents in the Istanbul Barinyurt Nursing Home and Elderly Care Center and their fall rates during 2016. By scoring risk of falling, high risk cases have been identified and where correlations existed between a fall and the risk off a fall. The rate of falling has been monitored with data collection and process monitoring forms.

Findings: A risk evaluation has been performed using the Itaki fall risk scale on all 97 elderly residents. 37 (36%) of these residents fell a total of 65 times. Of these 37 residents 10 residents fell more than once and a total of 38 times (21%). Out of 37, 4% is 60-65 years old, 2% is 66-75 years old, 9% is 77-84 years old and the remaining 22% is 85 and older. 41% of the fall cases was male and 59% were female. The falls occurred mainly in the residents' room (51%) and in the toilet or bathroom (20%).

In the fall risk evaluation, 3% of the elderly residents received a risk score of 1-9, 24% a risk score of 10-14 and 73% received a score of 15 or higher.

Conclusion: We have aimed to prevent fall cases in our institution by studying the risk of falls and identifying the reasons of falls by analyzing the falls which occurred due to the facilities and patients. In light of this, we have worked on an evaluation based on the risk of falling, the creation of institutional determinants and the safety of the environment and the equipment.

We have entered the elderly with a high risk of falling into the physiotherapy program. 40 staff members, primarily the care staff, have been given regular in-service training.

Monitoring of fall cases occurred while preventative measures were being implemented, as such there is no base-line against which the impact of the preventative measures can be definitively compared. However, the level of implementation increased during the course of the year and as such, it is safe to say that there was a lower rate of prevention during the first 6 months as compared to the last 6 months. When then comparing falls between the first and last 6 months of 2016, the instances of falls due to facilities have decreased from 8% to 3%, those as a consequence of care decreased from 2% to 0%.

While there has been a significant decrease of these specific preventable falls, there has been an increase in falls for other reasons causing the overall fall rate to remain very high. In particular falls when trying to get out of bed have increased, despite that alarm bracelets have been placed on each resident and that more attention has been given to residents taking high risk medications.

Keywords: Falling, Elderly, Nursing Home,

OP-53

INVESTIGATION OF VISUAL FUNCTION, BALANCE AND FALLING BEHAVIOURS IN ELDERLY PEOPLE WITH LOW VISION

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Introduction: Decreased visual information coming from the periphery in elderly individuals is the most important risk factor that causes deterioration in balance control and recurrent falling. The purpose of our study is to examine the visual function, balance states and falling behaviours in elderly individuals with low vision.

Method: For each participant, the information regarding acuity and defects of vision diagnosed by the ophthalmologist (according to Snellen) were recorded and on the same day, the patients were evaluated using one-to-one interview method. With 53 participants –aged 65 years and above– in each group, our study included a study group with individuals with low vision, and a control group with individuals having normal vision. Individuals' sociodemographic characteristics were recorded. Cognitive status was assessed by the Mini Mental State Examination (MMSE) and the quality of life with related vision was assessed by the National Eye Health Institute-Vision Function Questionnaire-39 (NEI-VFQ-39). Static and dynamic balance was the Berg Balance Scale (BBS), Functional Reach Test (FRT), Single Leg Standing Test (SLST), Timed up and Go Test (TUG). Falling behaviour was Falls Behavioural (FaB) Scale.

Result: According to gender distribution examination while in the study group 24 (45.28%) of the individuals were male and 29 (54.71%) were female, in the control group 25 (47.16%) were male and 28 (52.83%) were female. Groups are similar in terms of sex ($p>0.05$). Statistically significant difference was found in favor of control group in the NEI-VFQ-39 ($p<0.001$). No statistically significant difference was found between the groups in terms of BBS, SLST, TUG and FaB, which were used in evaluating the balance and falling behaviors of the individuals ($p>0.05$), but statistically significant difference was found in favor of the control group in FRT (p:0.027).

Discussion: In our study revealed that reduction in visual acuity is related with deteriorated quality of life with related vision and functional reach distance. The reason of not finding difference in other balance tests may be influenced by many individual and environmental factors such as side effects of drugs, fear of falling, etc. Protective behaviours of elderly individuals in both groups can cause no differences between groups.

Keywords: Vision,balance, falling behaviour, elderly

OP-54

RESTLESS LEG SYNDROME AND ASSOCIATED FACTORES

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Objective: Sleep disorders are prevelant but an underestimated problem in the elderly. Especially restless leg syndrome (RLS) is common among sleep disorders. Studies regarding prevalence and associated factors of RLS and are limited.We aimed to assess RLS prevelance and its associated factors.

Methods: We included the elders 60-99 years of age admitted to Istanbul Medical School Geriatrics outpatient clinic in 2013-2016 years period. International RLS diagnosis criteria was used for RLS diagnosis and Cardiovascular Health Study group criterias were used for frailty. Activities of daily living(ADL) and Instrumental activities of daily living(IADL) were defined by Katz/Lawton index. Handgrip strength was measured with jamar hydrolic dynamometer. Statistical methods were chi-square analysis, independent-T-test, logistic regression model analysis.

Results: 405 were male (%32), 854 (%68) were female from 1259 subjects. Mean age was 74,65±7 years. RLS prevelance was %28,4. Mean handgriph strength measurement was 26±8.5. Mean ADL and IADL were 17.2±1,39, 20,76± 4,6 respectively. Median frailty score was 1±1,192 (minimum score was=0 maximum score=5). After regression analysis, RLS was associated with IADL,frailty and lower handgriph strength ($p<0,001$, $p<0,001$, $p=0.13$ respectively). But it was not associated with ADL ($p=0,9$).

Conclusion: RLS is a geriatric syndrome associated with frailty, lower handgriph strength, and functional dependence. Frailty should be considered in patients with RLS. New studies are needed to light its pathophysiological mechanism.

Keywords: restless leg syndrome, fraility, functionality

OP-55

ONE OF THE FIRST IN GERIATRICS FIELD IN TURKEY THE AGED-FRIENDLY HOSPITAL PROJECT – IZMIR/TURKEY

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Introduction: Consistent with global trends, the older population of Turkey is growing rapidly. According to 2016 data from the Turkish Statistical Institute (TUIK), people over 65 years of age account for more than 8% of the total population. Izmir is the third largest city in Turkey and is preferred by older adults for various reasons such as the temperate climate of western Turkey, suitable topography and affordability. The proportion of elderly in the population is over 10% in many districts of Izmir and in some districts exceeds 15%. Projects have been initiated in response to healthcare demands in Izmir resulting from the rapid growth of the elderly population, the most important of which is the Aged -Friendly Hospital Project. The aim of this report was to describe a workshop which was carried out as one aspect of the Aged -Friendly Hospital Project and thus offer insight to those conducting similar studies.

Materials and Methods: The Aged Friendly Hospital Project was initiated in September 2015 with a large team consisting of academicians, civil organizations and older adults under the leadership of the Izmir Association of Public Hospitals Southern Region Secretariat and the Ege University Department of Geriatrics. After 9 months of preliminary study, a workshop was planned to bring together experts in the field to exchange ideas. This workshop was attended by a total of 79 professionals working in related occupations, including doctors of various specialties, gerontologists, nurses, social workers, architects, teachers, pharmacist, dieticians, psychologists and pharmacists. At

the workshop, the participants' views were solicited in 3 main areas: configuration of the physical structure, the organizational structure, and healthcare workers.

Results: At the end of the workshop, a list of architectural features necessary for an aged friendly hospital was compiled. It was determined that older adults require a well-lit environment and wide corridors and doors. The need for a quiet atmosphere was also stressed. It was emphasized that the structure of an elder-friendly hospital must be integrated with home care services. Training programs to increase knowledge and experience related to older adults were considered crucial to improve the understanding and compassion of aged friendly hospital staff toward the elderly. At the end of the workshop, it was decided to publish a consensus report in the form of a book. The aim was to use the criteria developed by consensus to determine the standards required for aged friendly hospitals. The objective was not to establish standards for Izmir only, but to develop national criteria that can be applied throughout Turkey. We believe that other countries with rapidly growing elderly populations should initiate similar projects immediately in order to meet rising healthcare demands.

Keywords: Aging, elderly, aged -friendly hospital,

OP-56

INCREASE OF CORYNEBACTERIUM STRIATUM PNEUMONITIS IN GERIATRIC PATIENTS

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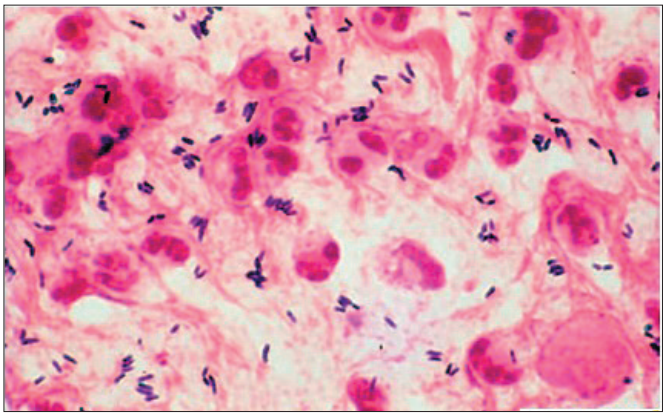
Aim: This study aims to emphasize the clinical significance of coryneform bacteria and to draw attention to the problems arising in microbiological diagnosis because coryneform bacteria mostly are considered as contamination and ruled out. It is an important pathogen in immunosuppressive and geriatric patients. We aim to evaluate the coryneform bacteria isolated in our hospital's microbiology laboratory together with the patient's clinical status.

Material and method: Cultures of sputum were incubated at 37°C for 24 hours by doing reduction planting on chocolate agar, 5% sheep blood and EMB medium and evaluated via a gram stain of mucoid material. The colonies from patients who had sputum of good quality and were thought to have pathogens in their lower respiratory tracts were identified. Blood cultures were taken as two sets and were loaded on the blood culture device. Gram staining was performed with the bacterial growths that gave signals, inoculating them on chocolate agar with 5% blood sheep and EMB medium or Sabouraud Dextrose Agar (SDA). Isolates are diagnosed as Corynebacterium striatum with VITEK2 MS automated diagnostic system.The strains with leucocytes and/or bacteria on Gram stain, dominant or absolute growth in culture, and growth in the repeated cultures were regarded as infectious agents while bacterial growths not fulfilling those criteria were reported as contamination or colonization.

Finding: Six geriatric patients admitted to intensive care unit with pneumonia and bacteremia due to C. striatum which was isolated from both blood and respiratory specimens sent simultaneously.

Conclusion: In this presentation, C. striatum, a member of coryneform bacteria, was isolated as causative agent in a patient with immunosupression, prolonged hospital stay , antibiotherapy and geriatric patients. We believe effective coordination between laboratory and clinician is much more important in such cases. In the evaluation performed according to CLSI guidelines between the years 2010 and 2013 the ciprofloxacin, penicillin, rifampicin, clindamycin, tetracycline, and gentamycin resistance were found as 83.0%, 80.0%, 79.1%, 73.2%, 69.9%, 41.2%, 17.6% respectively and also it was observed that all the strains were susceptible to vancomycin and linezolid. In the evaluation performed according to EUCAST guideline in 2014 it was observed that all strains were susceptible only to vancomycin and linezolid, and resistant to all other antimicrobials. Usually, Geriatric patients in intensive care unit are given antibiotic susceptibility treatment for the gram negative bacteria. whereas, C. striatum should be thought to be the causative pathogen.

Keywords: Corynebacterium striatum, Geriatric patient, Pneumonia



OP-57

APPROPRIATENESS OF STOPP/START CRITERIA FOR GERIATRIC TURKISH PATIENTS

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Introduction and Aim: Physiological, pharmacokinetic and pharmacodynamic changes are seen with aging. An inappropriate prescribing becomes inevitable along with these changes, comorbid conditions, involvement of different specialists and polypharmacy. An inappropriate prescribing is a growing public health problem and leads to adverse drug reactions that might cause undesirable/unwanted treatment outcomes. The Screening Tool of Older Person's Prescriptions (STOPP) and Screening Tool to Alert Doctors to Right Treatment (START) are the most commonly used criteria that were developed to evaluate appropriateness of prescribing in geriatric patients. Uncovered or inapplicable local criteria still exist in the recent version. Therefore, this study aims to determine appropriateness of STOPP/START criteria in geriatric Turkish patients.

Material and Methods: A prospective study was performed between September 2015 and May 2016 in a geriatric outpatient clinic at university hospital and two nursing homes by the involvement of clinical pharmacist. The patients aged 65 and over who use at least five medications were included. The study protocol was approved by the University Ethics Committee.

Overall geriatric assessment was performed by physician and detailed information about demographics, clinical data, medication history and current medical problems were collected by a clinical pharmacist. STOPP/START criteria were also performed by a clinical pharmacist to determine inappropriate prescribing.

Results: A total of 809 patients were included and 616 potentially inappropriate medication were detected in 400 patients. It was found that 19 out of 80 (23.8%) STOPP criteria have not been applicable for any medication or patient. These criteria (n) were detected in sections of central nervous system (4), drug indication (3), renal system

(3) endocrine system (3), respiratory system (2), analgesic drugs (2) and coagulation system (1) and drugs that predictably increase the risk of falls in older people section (1).

A total of 1855 potential prescribing omissions were obtained in 796 patients. It was found that 4 out of 34 (11.8%) START criteria (n) have not been applicable for any medication or patient including cardiovascular system (1), musculoskeletal system (1), urogenital system (1) and central nervous system & ophthalmic section (1).

Conclusion: STOPP/START criteria are important quality indicators in prescribing for geriatric patients. Since the first iteration of STOPP/START in 2008, they have been successfully applied in several countries in all over the world. In some countries STOPP/START software has been developed and integrated into routine clinical practice. Criteria also show promising results for Turkey but certain modifications might be necessary.

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Keywords: STOPP/START criteria, clinical pharmacy, appropriateness

OP-58

THE ROLE OF NF-KB IN THE ELDERLY WITH METABOLIC SYNDROME

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Objectives: Metabolic syndrome (MS) affects one third of population and it's frequency is inreasing with age. The etiopathogenesis of MS has not been understood clearly and a single genetic, infectious or environmental factor can't explain the etiopathogenesis of all components of the disease. Nuclear factor kappa beta (NF-κB) is one of the main mediators of inflammatory pathways. Recently, it has been emphasized that NF-κB-related inflammatory mechanisms play a key role in metabolic diseases such as obesity and type 2 DM (1). We aimed to investigate the role of NF-κB mediated mechanisms in the inflammatory process of elderly patients with MS in our study.

Method: 241 patients aged ≥18, 172 patients with MS who met the diagnostic criteria of International Diabetes Federation and 69 controls who applied to geriatrics and general internal medicine outpatient clinics for various reasons between 2015-2017 were included to the study. Patients were separated into four groups: young with MS (<60, n = 76), elderly with MS (≥60, n = 96), young control (<60, n = 31), elderly controls (≥60, n = 38).The groups were compared with demographic characteristics and all laboratory values including NF-κB among themselves (Table 1).

Results: Age and sex distribution were similar between MS and control groups.The height and weight of elderly MS are lower than young MS (p=0.001 ; p=0.007), there was no significant difference in body mass indexes. The older MS group was more hypertensive to young MS group and NF-κB levels were significantly higher (p <0.001, p = 0.01). Insulin resistance, impaired fasting glucose (IFG), HbA1c and triglyceride levels of the young MS group were statistically higher than elderly MS group respectively ((p<0.001; p=0.002; p=0.05; p=0.05). Levels of NF-κB were compared between young MS and control groups, no statistical significance was found. The NF-κB of elderly MS group were higher between elderly MS and elderly control group but not statistically significant. NF-κB level is positively correlated with age (r: 0.18, p: 0.01) and negatively correlated with IFG (r = -0.2; p = 0.004), HgbA1c (r = -0.17; P = 0.02) and DM (r = -0.2, p = 0.008).

Conclusion: Although recently studies have shown that NF-κB-associated inflammation is an important factor in the pathophysiology of metabolic diseases, not clearly understood yet. In our results, age-related correlation of NF-κB levels and statistical significance of NF-κB levels between the elderly-young MS groups; suggests that NF-κB may play an important role in pathophysiology of elderly MS. The association of being more hypertensive in elderly MS group with high NF-κB levels is needed to explore. Therefore, further investigation is needed to clarify the pathway of MS inflammation by NF-κB-related signaling mechanisms.

Keywords: Metabolic Syndrome, Elderly, NF-κB

Table 1. Comparison of demographic and biochemical data of the groups

	MS	*MS*	*p*	*Control*	*Control*	*p*
	Young n :76	*Elderly n :96*		*Young n : 31*	*Elderly n : 38*	
Sex(F/M)	1.75	2	0.6	1.4	1.5	0.8
Age (year)	51.1 ± 8.0	71.5 ± 7.4	<0.001	46.5 ± 7.7	71.7 ±7.0	<0.001
Height (cm)	164.5 ± 7.9	159.5 ± 9.5	<0.001	168.1 ±8.3	162.1±11.7	0.01
Weight(kg)	82.0 ± 13.8	76.3 ±1.,1	0.007	70.5±9.2	67.1±10.7	0.16
BMI(kg/cm2)	30.3 ± 5.1	30.1 ± 5.4	0.74	24.9±2.6	25.6±4.2	0.37
Waist circumference (cm)	99.9 ± 11.1	100.3 ±11.2	0.80	82.9±9.2	87.0±13.4	0.5
HT	%76.3 (58)	%95.8 (92)	<0.001	%16.1(5)	%28.9 (11)	0.2
DM	% 52	% 46.9	0.45	%3.2 (1)	% 0 (0)	0.3
IFG	0.53 ± 0.50	0.50 ± 0.50	0.002	0.0	0.26 ± 0.16	0.3
HDL	% 56.6	% 45.8	0.16	% 16.1 (5)	%28.9 (11)	0.1
Triglyceride	% 56.6	% 51.1	0.05	% 6.5 (2)	%2.6 (1)	0.4
Insulin resistance	% 77.6	% 45.8	0.00	% 9.7 (3)	%7.9 (3)	0.2
CRP mgr/L	5.79 ±6.1	4.9 ±5.2	0.34	3.4±.4.0	3.6±5.2	0.8
SED(mm/saat)	19.9±16.0	2.1 ± 18.9	0.06	12.8±7.8	18.2±12.0	0.03
HgA1c (%)	6.65 ± 1.4	6.2 ± 1.3	0.05	5.2 ± 0.4	5.4 ± 0.4	0.09
NF-κB ng/ml	2.83±1.59	3.53±2.10	0.01	3.2 ± 2.1	3.1 ± 1.6	0.7

OP-59

PREVALENCE OF OSTEOSARCOPENIA AND RELATED FACTORS IN THE ELDERLY PATIENTS

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Introduction: Osteosarcopenia is a newly defined condition that consists of both sarcopenia and osteoporosis in an elderly patient. The studies investigating the patients with osteosarcopenia are limited. We planned a study to find out the prevalence and the related factors of osteosarcopenia.

Material and Methods: This study was conducted in a geriatric outpatient clinic of a tertiary University hospital. 171 patients who had bone mineral densitometry (BMD) performed on a routine basis within last one year were included in the study. All patients underwent comprehensive geriatric assessment including the evaluation of co-morbidities, medications, activities of daily living, nutritional status, cognitive functions and mood changes. Sarcopenia was defined as loss of skeletal muscle mass evaluated by bioelectrical impedance analysis plus at least one of the following situations; low handgrip strength or slow walking speed.

Results: The median age of the patients was 74 years (min-max: 65-91) and 60.8% was female. The prevalence of the sarcopenia and osteosarcopenia were 13.5% (23/171) and 7.0% (12/171), respectively. Sarcopenia was more common in patients with low BMD than patients without (21.1% vs. 9.6%, respectively, p=0.039). The patients with osteosarcopenia had worse results of height, weight and body mass index (BMI), calf circumferences, handgrip strength, walking speed, basic and instrumental activities of daily livings, clock drawing and mini-mental state examination tests scores and mini-nutritional assessment compared to the non-osteosarcopenic patients (all parameters had p<0.05). In multivariate analysis, calf circumferences (OR: 0.595, p=0.011), clock drawing test (OR: 0.597, p=0.024) and BMI (OR: 0.716, p=0.032) were found to be independently correlated factors for osteosarcopenia.

Conclusion: The study has shown that nearly half of the sarcopenic patients may also be osteosarcopenic (12/23). Moreover, approximately each one of the five elderly patients with low BMD may be sarcopenic.

Keywords: Osteosarcopenia, prevalence

OP-60

THE PREVALENCE OF SARCOPENIA AND ASSOCIATED FACTORS AMONG HOSPITALIZED OLDER PEOPLE

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Objective: Sarcopenia is an important public health problem that affect mostly older people, and has negative health outcomes such as disability and even death [1]. Although data exist on the prevalence of sarcopenia in community dwelling older people and nursing home residents, data on the hospitalized older people are scarce [2]. The aim of this study was to evaluate the frequency of sarcopenia and associated factors among older people in two different hospitals in Ankara/Turkey.

Material and Method: A cross-sectional study was conducted in hospitalized older people. 146 older adult ≥65 years old were recruited from two different hospitals (university hospital and training research hospital). Demographic data, medications, co-morbidities were recorded at admission. Activities of daily living, nutritional status and cognitive function were assessed. Length of hospital stay was also calculated. Sarcopenia was defined according to the European Working Group on Sarcopenia in Older People. Univariate and multivariate regression models were used in order to identify factors associated with sarcopenia.

Results: Median of age was 78 (65-99) and 53.4% of participants were female. The prevalence of sarcopenia was 25.3% (37). There are more sarcopenic males (35.3% (24)) than females (16.7% (13)) (p=0.013). Sarcopenic participants had lower scores on instrumental activities of daily living (4.5(0-8)) and mini mental state examination score (17(3-30)) compared to participants without sarcopenia (6(0-8), 24.5(7-30)), (p=0.015, p=0.03) respectively. Body mass index (OR: 0.86 (CI 95% 0.79-0.96), p=0.01) age (OR: 1.05 (CI 95% 1-1.1), p=0.034), male gender (OR: 2.72 (CI %95 1.25-5.92), p=0.011), instrumental activities of daily living (OR: 0.83 (CI 95% 0.73-0.95) and mini mental state examination score (OR: 0.92 (CI 95% 0.88-0.97), p=0.003) were associated with sarcopenia in univariate analysis. Variables associated with sarcopenia in univariate regression analysis were used in multivariate regression analysis. Body mass index (OR: 0.89 (CI 95% 0.81-0.98), p=0.027), mini mental state examination (OR: 0.92 (CI 95% 0.85-0.99), p=0.033) and male gender (OR: 3.11 (CI 95% 1.22-7.91), p=0.017) were independently associated with sarcopenia in multivariate analysis.

Conclusion: Sarcopenia is frequent in older hospitalized patients. Sarcopenia should be a part of evaluation of hospitalized older people.

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Keywords: elderly, hospital, sarcopenia

OP-61

FRAGILITY IS THE NEWLY DEFINED CAUSE OF OROPHARYNGEAL DYSPHAGIA REGARDLESS

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Objectıve: Oropharyngeal dysphagia is a prevalent geriatric syndrome among aging adults. This clinical problem is associated with deterioration in functionality, malnutrition, infections, and increases in mortality which is usually ignored. As well known, the rate of oropharyngeal dysphagia is high in neurodegenerative diseases. Fragility is also a geriatric syndrome that is well known and effecting the prognosis. In recent years, literature has been suggested dysphagia may be present in fragile elderly without neurodegenerative diseases. We aimed to investigate the association of oropharyngeal dysphagia with fragility in the community dwelling elderly.

Materials and Methods: The study includes patients admitted to our outpatient clinic prospectively. Participants' demographic data and the other measurements were recorded. Age, gender, total number of illnesses, total number of medicines were examined. Dysphagia screening was done by scanning the EAT-10 questionnaire. Two thresholds were used for the EAT-10 survey (≥3 and ≥15). The International Association of Nutrition and Aging's FRAIL Scale was applied to determine the fragilty. We performed the measurements of BMI, hand grip strength, calf circumference, time and go test(TUG), usual walking speed, activities of daily living (ADL), instrumental activities of daily living (IADL) and MNA-SF. Statistical analysis tested for association between these parameters and dysphagia .

Results: 1138 patients≥60 years old who were admitted to our outpatient clinic were enrolled from July 2015 to September 2016. The mean age of the elderly was 74.1± 7.3 (60-98). 348 (30.6 %) were male and 790 (69.4%) were female. The EAT 10 survey was conducted on all participants. The fragility status was determined by the FRAIL scale in 851 subjects. In the statistical analyzes , EAT 10 score correlated with age, number of illnesses, number of medications, fragility, BMI, hand grip strength, TUG, usual walking speed, ADL, IADL and MNA SF according to the two thresholds of EAT -10 groups. In addition, there was a higher incidence of female gender, number of neurodegenerative diseases, and a fall and a fall risk in the EAT 10 score ≥3 and ≥ 15 groups. In the linear regression analysis, EAT 10 score ≥3 (n=65, 7.6%, p<0.012) and EAT 10 score ≥15 (n = 33, 3.8 % , p <0.001) were found to be correlated with fragility irrespectively.

Conclusion: Oropharyngeal dysphagia in the elderly living in the community is a common public health problem that is widespread and difficult to recognize which can be associated with severe mortality. We have shown that oropharyngeal dysphagia increases with fragility. To our knowledge, this is the largest serie in the literature providing data on independent association of dysphagia with frailty.

Keywords: Oropharyngeal dysphagia, frailty, community dwelling elderly

OP-62

URINARY INCONTINANCE AND SARCOPENIA: A NEW INSIGHT

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Purpose: Urinary incontinence (UI) is a common cause of morbidity in the elderly. Identification of factors associated with urinary incontinence is necessary to identify risky individuals and to take preventive measures. Sarcopenia and fragility are the leading geriatric syndromes in elderly. We suggest that sarcopenia may facilitate urinary incontinence by decrease in muscle mass/strength. In this study, it was aimed to investigate the relationship of urinary incontinence and sarcopenia in a large group of elderly people.

Methods: Elderly people between the ages of 60-99 who applied to geriatric polyclinic were included in the study. Demographic, clinical data, UI and its types were obtained. Body mass index(BMI), hand grip strength and walking speed were assesed by using physical examination. Muscle mass was measured by bioimpedance analysis (TANITA-BC532). Low muscle mass thresholds were assessed according to national data (Muscle mass adjusted by height for women <7.4 kg / m2, for men <9.2 kg / m2; muscle mass adjusted by weight for women <33.6% , for men <37.4 %; muscle mass adjusted by BMI for women <0.82 kg/BMI, for men <1.05kg/BMI, another treshold for muscle mass adjusted by BMI for women<0.68 kg/BMI, men <1.02 kg/BMI , for men <1.02 kg / BMI)

Results: The prevalance of UI was %46.2 (601/1302). The most common type was urge UI(%48.2). Mix UI was % 28.2, stress inkontinance %13.2, overflow inkontinans %3.7 and functional urinary incontinance was %6.8. Associated factors with UI were gender, age, drug number, body mass index, fecal incontinence, konstipation, falls, sleep disorders, frailty, activities of daily living, instrumental activities of daily living, grip strength, walking speed, bia muscle, skeletal muscle mass, muscle mass adjusted by weight and BMI in bivariate analyses. Independent factors related with UI in regression analysis models; Fecal incontinence, drug number, frailty and instrumental activities of daily living. While hand grip strength was not associated with UI, muscle mass adjusted by weight and body mass index was found to be related to urinary incontinence.

Conclusion: The results of our study show that UI is independently associated with sarcopenia and frailty. Treatment of sarcopenia may have a positive effect on UI.

Keywords: Urinary incontinence, sarcopenia

ULUSLARARASI AKADEMİK GERİATRİ KONGRESİ

2017

POSTER PRESENTATIONS

PP-01

A NEW DESIGNED APPROACH FOR RISK STRATIFICATION IN THE PLAN OF EXERCISE IN OLDER ADULTS

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Physical activity is any body movements caused to energy expenditure that is organized jointly or collectively with the family, including leisure activities (dancing, playing, gardening), activities to get from one place to another (walking, running, cycling), work, housework (cleaning), sports (swimming, tennis, golf) or planned exercise activities.

The benefits of physical activity, increasing life span and decreasing morbidity and mortality have been proven at all ages, even in later life. In addition, it has helpful effects on the improvement of the quality of life and the maintenance of social and psychological well-being.

There are four various types of physical activity including aerobic exercise, muscle-strengthening, flexibility, and balance.

There are a lot of specific programs and their implementations, and recommendations for adults aged over 65 years, but it is hard to say that the adherence and the persistence of individuals are in the desired levels in clinical practice. To struggle with these problems, an exercise plan with specific recommendations should be constituted to individualize in older adults. While planning a private exercise, to consider chronic conditions and functional limitations limiting activity could be helpful for a systematical approach.

This new designed approach is suggested to address these domains. The subjects are divided to three different groups with this tool based on chronic conditions, cognitive status, functionality, and activities of daily living.

1. Low risk group: Those with a chronic disease, without cognitive impairment, with no functional disability, being independent in their daily life activities.
2. Medium risk group: Those who have two or more chronic illnesses, with mild cognitive impairments, with mild functional disabilities (using canes, walkers, etc.), being semi-independent in their daily living activities.
3. High risk group: Those with two or more chronic illnesses, with significant cognitive impairment, with advanced functional disability or bed bound, being fully dependent on daily living activities.

Encouraging older adults to physical activity is important issue. There are still problems to constitute an activity plan in this population. Therefore, comorbidities and physical status are required to be assessed to ensure an ongoing plan and achieve the targeted outcomes. Further studies are needed to test the availability and the implementation of this risk categorization in older adults.

Keywords: Exercise, risk stratification,

PP-02

SAFE TRANSITIONS FOR AT RISK PATIENTS (STAR) PROGRAM FOR TURKEY

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The older adult at high risk safety problem during transitions between care settings has become a huge public health problem. The care needs of this population are required to be assessed with a multifactorial approach due to increasing comorbidities, physical and physiological changes, environmental risks, social and lifestyle factors, and nutrition. Safe Transitions for at risk Patients (STAR) program has been developed to address patient's safety problem of potentially preventable hospital readmissions among older adults who are at high risk for complications during transitions. This program targets on the population most impacted by the patient safety risks of PPHR and includes patients admitted to the hospital who are age 75 and older and have one or more of the following: 1) hospital readmission within 30 days; 2) two or more inpatient admissions in the previous 6 months; 3) Polypharmacy (9 or more routine prescription medications) on admission; 4) Delirium and/or history of dementia on admission; 5) Admission related syncope/fall/dizziness/weakness or acute renal failure/volume depletion/dehydration or shortness of breath related congestive heart failure or COPD exacerbation or failure to thrive. Initially, this program will be started only in the form of consultation services that is given in out-patient clinic, clinic, and emergency department. Furthermore, it could be changed an intervention used in emergency department like STAR program in future. There is a growing older population in Turkey which is in the process of demographic transition and it has to be taken steps toward to meet this challenge by building "Program Culture". STAR program for Turkey, which aims at meeting future needs in the care of older patients at high risk, has been created by modifying STAR program. This adapted program has been prepared in accordance with health system requirements in Turkey. Testing of this patient-centered intervention can increase the quality of geriatric care while adverse outcomes and potentially preventable readmissions decrease and provide economic benefits.

Keywords: Aged, patient care management, hospital readmission

PP-03

SELF-REPORTED HEARING LOSS IS ASSOCIATED WITH FRAILTY AMONG AFRO-CARIBBEANS

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Objective: Data on ethnic differences in the relationship between hearing loss and frailty are sparse. We investigated the relationship between self-reported hearing loss and frailty in four ethnic groups.

Methods: This is a cross-sectional study of a community-dwelling sample of African American, Afro-Caribbean, Hispanic, and European American individuals aged 60 or older (n = 484). Participants had to be able to ambulate independently or with the help of a device, and have an age and education-adjusted Mini-Mental State Examination score > 23 to be enrolled. Self-reported hearing loss was measured by a single question: "Is your hearing excellent, very good, good, fair, or poor?". Answers of excellent, very good, and good

were considered as "no hearing loss" and answers of fair and poor as "self-reported hearing loss". Frailty status was defined as reporting ≥ 3 of the following criteria: weight loss, weakness, exhaustion, slow walking speed, and low physical activity.

Results: In unadjusted and adjusted models, self-reported hearing loss was associated with frailty in Afro-Caribbeans (OR=3.075; 95% CI: 1.149–8.233; p=0.025 and OR=7.509; 95% CI: 1.797–31.386; p=0.006), but not in African Americans, Hispanics and European Americans. Out of the five frailty criteria, only exhaustion was significantly more common in the self-reported hearing loss group among Afro-Caribbeans.

Conclusion: Self-reported hearing loss was associated with frailty among Afro-Caribbeans, and this association was largely due to the frailty criterion of exhaustion.

Keywords: Hearing loss, frailty, older adult

PP-04

POOR SLEEP QUALITY IS AN INDEPENDENT RISK FACTOR FOR DISABILITY IN DEMENTIA PATIENTS

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Introduction: The aim of this study was to evaluate the association between sleep quality and functional status in patients with dementia.

Methods: Sixty two (38 female and 24 men) community dwelling older adults with dementia who admitted to a Geriatric Outpatient Clinic and was not taking any cholinesterase inhibitors were enrolled to the study. All patients were diagnosed using 'Diagnostic and Statistical Manual of Mental Disorders-IV'criteria for dementia. Barthel Activities of Daily Living (ADL) scales and Pittsburgh Sleep Quality Index (PSQI) were used for functional status and sleep quality. Functional disability was defined as a Barthel ADL score of ≤95. Higher and lower scores in PSQI test indicated worse and better sleep quality, respectively. A PSQI score ≥5 indicated poor sleep quality.

Results: 82.1% of patients had functional disability and 72.1% had poor sleep quality. ADL scores were negatively correlated with PSQI scores (r=-0.445, p=0.001). Advanced age, high body mass index, poor sleep quality, and depression were found to be potential risk factors for functional disability in the univariate analysis. In the multivariate analysis, only poor sleep quality was found to be independent risk factor for functional disability (OR=0.350; 95% CI=0.086–0.614; p=0.011).

Conclusions: We found that the risk of functional disability increases in dementia patients with poor sleep quality. The result emphasis that physicians interested in cognitive impairment should not only focus on dementia treatment, but must also assess sleep quality in order to identify dementia patients at risk for functional disability.

Keywords: sleep, disability, dementia

PP-05

AN APPROACH TO COGNITIVE DYSFUNCTION IN FRAIL OLDER ADULT WITH WEIGHT LOSS

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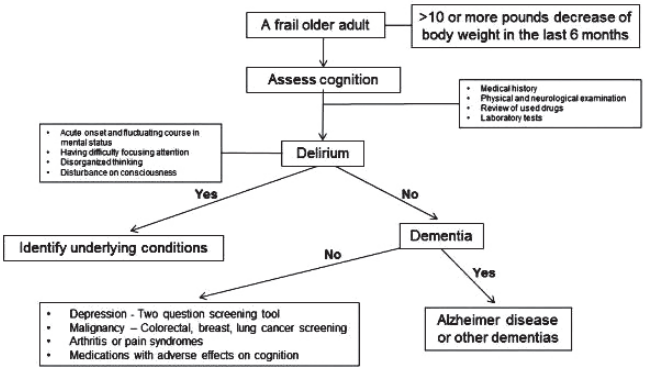
Weight loss is a clinical condition that increases the morbidity and mortality risk in elderly. The diagnosis of weight loss, especially in elderly population is important to prevent or treat underlying causes because it may emerge at the beginning or during the course of any disease. Weight loss is one of the core criteria of frailty syndrome. Some reports have indicated that frailty syndrome is associated with cognitive dysfunction in older adults. Here a diagnostic approach to cognitive assessment in frail older adult with weight loss is reported.

>10 or more pounds decrease of body weight in the last 6 months is clinically important in frailty. If this comorbidity is present, the initial step of cognitive assessment in the frail older adult begins with medical history, physical and neurological examination, the review of used drugs, and laboratory tests to exclude acute confusional states. Acute onset and fluctuating course in mental status, having difficulty focusing attention, disorganized thinking, and disturbance on consciousness characterize acute confusional states. If a delirious state is excluded, then dementia is needed to be assessed. Depression, malignancy, arthritis, and medications could be mostly confused with dementia syndromes in this population. Screening tools could be helpful to distinguish depression from dementia. Cancer screening recommendations (colorectal, breast, lung) could be performed to diagnose underlying malignancy. Medications with adverse effects on cognition could be reviewed. Arthritis or pain syndromes could be reviewed via tools and specifically designed questions. If these conditions are excluded, underlying dementia syndromes (Alzheimer dementia or other subtypes) are identified in the last step.

A comprehensive intervention in frail older adults with cognitive dysfunction and weight loss has beneficial effect on the prevention and progression of underlying conditions, decreasing morbidity and mortality. Further research will be required to determine how useful these recommendations are in clinical practice.

Keywords: cognitive dysfunction, frailty, weight loss



PP-07

WHO IS OLDER PATIENT AT HIGH RISK?

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Introduction: Acute and post-acute care of older adult is a process fraught with problems. The aim of this article is to describe patient at high risk of complications during transitions between care settings.

Patient at high risk: Elderly patient at high risk is an individual who has to make more frequent hospital admissions due to developed complications, is faced with the constant risk of hospitalization, and has increased risk of functional decline, nursing home admittance, and death. These adverse outcomes cause discrepancies and problems in the implementation and the regulation of treatment, and coordination between health entities.

Factors increasing these risks vary in these individuals, but the existing chronic diseases and geriatric syndromes are the most important underlying causes. Identification of elderly patients at high risk is difficult because of the complex and entered into each other syndromes, chronic diseases, and care and socio-economic problems. Patients at high risk are under risk for unplanned hospital readmissions. Discharged one out of every 4 or 5 elderly at high risk is admitted to the hospital within the first month.

Conclusion: In these patients, early diagnosis, followed by a multi-disciplinary team, enhanced discharge planning, medication reconciliation and out of hospital care will contribute to improving the quality of care and be able to provide to use more efficiently the resources. In our country, there is a need for patient-centered programs on this issue.

Keywords: older adult, hospital admissions, risk

PP-08

INSOMNIA AND DELIRIUM DUE TO COMPLEX REGIONAL PAIN SYNDROME IN AN OLDER PATIENT WITH DEMENTIA

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A 78 year-old men with mild to moderate Alzheimer's dementia (AD) was referred with two weeks history of difficulty in falling asleep, hallucination, restless, and agitation. He had hit his left hand on the door severely three weeks ago. Swelling, pain, and coldness in the left hand had started within one day following trauma. He had severe pain that affects functionality and quality of life.

On exam, his left hand and wrist seemed swollen, edematous, and cyanotic. It was colder than the other hand and tender to touch. He was unable to move his left hand and wrist. He was confused and disoriented. His recent memory and attention status were impaired. Laboratory data did not reveal abnormalities.

He was diagnosed as insomnia and delirium superimposed on dementia. Both comorbidities were attributed to pain due to CRPS. There was no other factor to explain the underlying cause of comorbidities. To relieve pain, topical analgesic and paracetamol were started. One week later, physical findings of CRPS were decreased, insomnia and delirium was disappeared.

CRPS is a condition that usually affects distal limbs and is characterized by pain and altered sensation, swelling, limited range of motion, vasomotor instability, discoloration, and patchy bone demineralization.

Conclusion: This is the first report of insomnia and delirium due to CRPS in a patient with AD. Pain in patients with AD seems frequently to be overlooked, underestimated, and undertreated. If pain does not adequately treated, it can cause various behavioral problems, sleep disturbance, delirium, and progression in dementia patients.

Keywords: complex regional pain syndrome, older adult, dementia

PP-09

NEUROLOGICAL DISABILITY IN OLDER PATIENT

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Introduction: The final status is March 30, 2013; "The Regulation on the Reports of the Health Board" to be given to the disabled people by entering into force in the Official Gazette No. 28603 describes the definition of disability and how the health board reports should be given to the disabled people. There are few studies in our country regarding patients who have applied for a neurological disease to the relevant health institution and have received a percentage of the disable. In this study, our center which has central hospital characteristics in the South and Southeastern Anatolia region was evaluated as 65 years old and over with the percentage of the disabled due to the presence of neurological disease.

Material and Method: The cases studied were taken from patients who applied for a medical report to the neurology clinic for a period of January to December. In the policlinic, firstly the neurology specialist assessed and diagnosed and the diagnosis was made for the health board of the neurology department and according to the legislation published in the official gazette dated March 30, 2013 and numbered 28603, Referred cases for consultation with other institutions or to receive a health report from the courts are excluded from the study. The data of the cases that were taken into the study were retrospectively and their findings were documented by determining their age, gender, diagnosis and the rates of disability they had. In the classification according to the diagnosis, primary diagnoses were considered and additional diagnoses were not consideration.

Findings: A total of 505 patients who received a percentage of disability due to neurological disease were included in the study, of which 181 (35.8%) were 65 years of age or older. Ninety four (51.9%) of them were male and 86 (47.5%) were female. The average age of men was 73.7 ± 7.1 (65–89) years, the average age of women was 75.2 ± 7.6 (65–97) years determined, and the average age of men was lower than that of women. ($p<001$) Average disability rates according to the Baltazar formula; 89.1% ± 6.9% (5–100) in males and 75.8 ± 14.9% (20–90%) in females were statistically significant in favor of males ($p<001$).

When the cases were classified according to their diagnosis, it was determined that dementia (n: 70), stroke (n: 61) and Parkinson's disease (n: 19) were in the first three ranks according to their frequency, followed by spinal diseases, epilepsy and neuromuscular diseases.

Results: For people above 65 years-old, the rate of neurological disability is at middle-high level and diseases such as strike that have presentable risk factors are often observed. It has attracted attention that not enough information was given about the prevention of diseases such as dementia, Parkinson's disease in which genetic causes played a role in etiopathogenesis and also genetic counseling service was not sufficiently provided.

Keywords: Neurology, disability rate, older patient

PP-10

LONGITUDINAL ASSOCIATIONS OF NUTRITIONAL STATUS AND BODY COMPOSITION WITH OUTCOMES IN THE ELDERLY-PRELIMINARY RESULTS

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Objective: Nutritional status in the elderly is substantial, because of the impact on morbidity and mortality. Both undernutrition and obesity increase the risk of frailty in community-dwelling older individuals. We aimed to investigate body composition and nutritional status of the elderly in the outpatient clinic of internal medicine, and the relationships between each other, and to follow them after dietary advices by the same dietician in the first 6 months for nutritional status, body composition, gait speed and hand grip strength; and after 12 months for activities of daily living (ADL)-instrumental ADL (IADL) disability, institutionalisation, hospitalization, falls, fall-related injuries and mortality. Material Methods: Patients with ≥65 years of age consulted by the same dietician in the internal medicine outpatient clinic were included in the study. Mean age, body mass index (BMI), waist circumference (C), hip C, waist/hip ratio, fat-free mass (FFM), FFM index (FFMI) as FFM/height squared, mini nutritional assessment-short form (MNA-SF) score, prealbumin and high-sensitivity CRP (hsCRP) levels, calf circumference (CC) values of the patients are shown in Table 1. Patients who are assessed by the dietician and evaluated as at risk of malnutrition were adviced protein and energy-rich diets when applicable. We are presenting the first cross-sectional results. Results: A total of 85 patients with ≥65 years of age were included in the study. All were independent in ADL and IADL. Age of 38 patients (44.7%) were <70 years of age, where 47 (55.3%) were ≥70 years of age. There was no difference in BMI groups classified as normal weight, obese or underweight between age groups > and <70 years of age (P = 0.46). Relationships between the parameters will be discussed.

Conclusions: Most (98.8%) of the elderly patients consulted by dietician in a period of time were normal to obese for BMI which is interesting for body composition of outpatient internal medicine clinic profile. It may be assumed that clinicians seek for consultation of dietician mostly for overweight situations, or patients with normal to overweight were healthy enough to look for dietician consultation.

Keywords: Nutritional status, body composition, dietary advice, elderly, outcomes

Table 1. Characteristics of the patients (n = 85)

Age (years)	72.2 ± 5.8 (65–88)
Women, n (%)	62 (72.9)
Diabetes mellitus, n (%)	29 (34.1)
Hypertension, n (%)	48 (56.5)
BMI (kg/m2)	28.9 ± 5.3 (18.5–45)
Underweight (<18.5), n (%)	1 (1.2)
Underweight (<20, <70), n (%)	1 (1.2)
Underweight (<22, >70), n (%)	5 (5.9)
Obese (≥30), n (%)	33 (38.8)
MNA-SF score	11.7 ± 2.7 (3–14)
Malnourished, n (%)	7 (8.2)
Prealbumin (mg/dL)*	20.9 ± 5.2 (7–30)
Nutritional severe risk, n (%)	3 (3.8)
hs-CRP (mg/dL)	0.74 ± 1.3 (0.03–6.6)
FFMI (kg/m^2)	18.4 ± 2.4 (12.5–27.1)
CC (cm)	36.8 ± 3.4 (30–45)
Waist circumference (cm)	96.1 ± 13.1 (72–145)
Hip circumference (cm)	108.4 ± 10.4 (88–144)

PP-11

CAUSE OF DYSPHAGIA IN GERIATRIC AGE GROUP; DIFFUSE IDIOPATHIC SKELETAL HYPEROSTOSIS

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Cukurova University School Of Medicine

Introduction: Diffuse Idiopathic Skeletal Hyperostosis (DISH) is a disease characterized by tendon, ligament or new bone formation in some bone regions that ocur without degenerative, traumatic or post-infectious changes. In this study, three cases diagnosed with different neurological diagnosis area and DISH are presented.

Case 1: A 77-year-old male patient consulted with complaints of swallowing difficulty. He had diagnosed Myastenia gravis two months ago in an external center and he had not responded to the treatment of pyridostigmine. Neurological examination; speech was hypophonic. AchRab level was negative. Repetitive nerve stimulation was normal. On lateral cervical graph, osteophytic changes, ligamentous calcifications and osseous hypertrophic changes were observed in the anterior part of the C3-C7 vertebra corpus. In nasopharyngeal CT, large osteophytic changes were observed that spanned significant hypopharynx at the C3-C4 vertebra level, and calcification and osteophytic changes in the posterior longitudinal ligament were observed in the spinal canal at C3-C4 vertebra level. He was diagnosed as DISH.

Case2: A 71-year-old male patient with a diagnosis of myasthenia gravis was admitted to our hospital with increased swallowing difficulty. Neurological examination; speech was nasone semipitosis in the right, quadriparesis at 4/5 level in the proximal muscle groups. On the lateral cervical direct graph, osteophytic changes evident in the anterior corpus of the C3-C7 vertebra and ligamentous calcifications were observed. Cervical MRI showed C3-C4, C6-C7 median disc protrusion, spinal cord compression as well as C3-C7 vertebra corpus anterior osteophyte formation and esophageal compression. He was diagnosed DISH.

Case3: A 65-year-old male patient was admitted to the clinic with complaints of increased swallowing difficulty and speech impairment which has been present for more than one year. It was determined that he had been operated due to a prolongation in the neck bones in an external center one month ago. Neurological examination; speech is dysarthric, atrophy and fasciculation are present in tongue. GAG

reflex could not be obtained. Anterior horn cell involvement detected by EMG. On the lateral cervical direct graph, osteophytic changes and anterior ligamentous calcifications were observed in the anterior part of all cervical vertebral level. Cervical MRI: osteophytes with a tendency to anastomotic laminae at the entire cervical level and ligament ossifications pressing on pharynx and hypopharynx lumen were present. He was diagnosed as bulbar onset ALS and DISH.

Result: As we have presented in our cases, in patients with severe swallowing in the geriatric age group, the presence of DISH should be investigated if it contributes to dysphagia, although there is a neurological disease that can explain this clinical status or not, and also differential diagnosis should be kept in mind in patients with swallowing difficulty.

Keywords: swallowing, amiyotrophic lateral sclerosis, Myastenia gravis, DISH

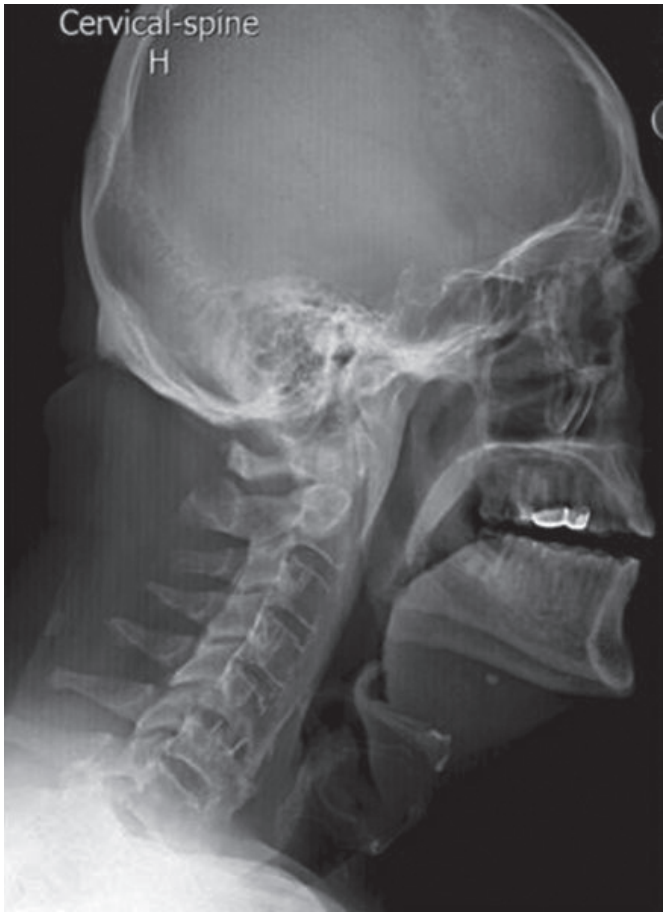

Figure 1.

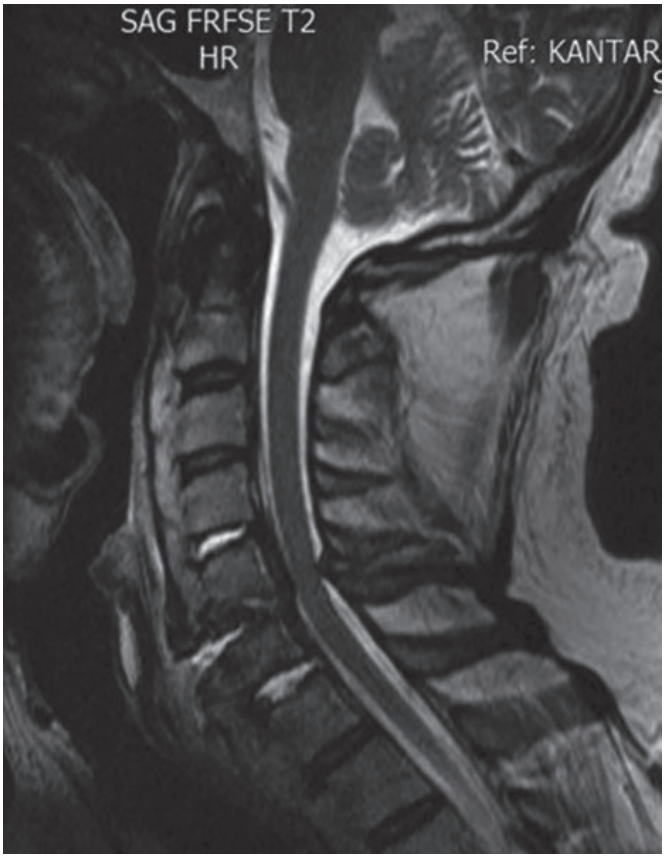

Figure 2.

PP-12

HIGHER RISK OF PERIPHERAL ARTERIAL DISEASE IN COGNITIVE DECLINE: RESULTS FROM A TURKISH SAMPLE FREE OF TRUE DEMENTIA

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Aims: Peripheral arterial disease (PAD), a marker of established systemic atherosclerosis is a prevalent condition among elderly. Its presence is equivalent to coronary heart disease or stroke in terms of cardiovascular outcomes and mortality. Accelerated cognitive decline in individuals with PAD was previously reported in other populations. Frequency of both PAD and cognitive impairment among older adults vary in different populations. The present study investigated PAD prevalence among non-demented Turkish elderly with different levels of cognitive performance.

Materials and Methods: Cognitive functions were rated by the mini mental state examination (MMSE) test. PAD was diagnosed by the ankle brachial index (ABI). A low ABI was accepted ≤0.9. Presence of dementia was evaluated clinically and these subjects were excluded.

Results: The study included 662 individuals aged 65 years or older (mean age: 74.97±6.4). There were 418 women (mean age: 74.31±6.27), and 244 men (mean age: 76.09±6.48). Overall prevalence of PAD was 13.1%. Both crude and age adjusted logMMSE correlated positively to logABI (beta: 104, p=0.008). Mean ABI was similar across MMSE score classifications (MMSE ≥25, 21 to 24, and 10 to 20 points). However, age adjusted PAD prevalence was signifi-

cantly different among the three MMSE classifications (MMSE ≥25 points: 11.8%, 21 to 24 points: 30%, and 10 to 20 points: 11.1%, p=0.001). When MMSE scores were categorized as ≥25 and <25, frequency of PAD was significantly higher in the lower cognitive performance group (MMSE ≥25:11.8% vs. <25:27.1%, p=0.001) after adjustment for age.

Conclusions: 1) Individuals with cognitive decline had 2.3 folds higher frequency of PAD. 2) Subjects with MMSE scores lower than 25 has more systemic atherosclerotic burden. 3) The results are in accordance with those obtained in other populations. 4) Benefits of more intense follow-up of men and women with cognitive decline in terms of cardiovascular risk modification and/or treatment warrants further research.

Keywords: peripheral arterial disease, ankle brachial index, cognitive decline

PP-13

NAUSEA AND HYPOMAGNESEMIA: A CASE OF DIGOXIN INTOXICATION IN AN ELDERLY PATIENT

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Introduction: Nause is a one of common complaints for elderly people. It has a broad spectrum of differantial diagnosis. At the other side, digoxin isn't one of the first-choice drug treatment of heart failure today but it is still used by some doctors in the front line. Hypomagnesemia is a particularly common electrolyte disorder especially in diabetic patients. Hypomagnesemia may precipitate or aggregate the digoxin intoxication. We present here a case of digoxin intoxication who was admitted with nausea.

Case report: 76-year-old male patient was admitted to the Internal Medicine Clinic because of nausea. He had history of hypertension, chroinc obstructive pulmonary disease, diabetes mellitus and heart failure. Two months ago, he had admitted an outpatient clinic for exhaustion. Digoxin 0.25 mg had been initiated for heart failure. But two weeks later after digoxin treatment, progressive nausea had been emerged and his oral intake was reduced because of this. On physical examination, vital signs were stable and there were no signs of heart failure. On laboratory creatinine: 1.32 mg/dl, urea: 46 mg/dL, potassium 4.6 mg/dL, magnesium: 1.5 mg/dL (1.8–2.6), Calcium: 8.83 mg/dL and Pro BNP 890 pg/nl (0–400) were detected respectively. ECG was in sinus rhythm and sagging sign was observed. Although the patient had not been taking digoxin for two days, blood digoxin level detected 2.15 (0.8 to 2.0). After discontinuation of treatment with digoxin and repletion of magnesium, his admission complaint disappeared completely. On the echocardiography, the patient's ejection fraction was% 40 and heart failure therapy was edited with valsartan and carvedilol. In the following days, patient discharged and outpatient control was suggested.

Conclusion: Nausea is a common complaint for patients of all ages. For nausea evaluation, it is important to take full-drug history especially in the elderly patient group. Digoxin is a drug with a narrow margin of safety. Several factors may increase the plasma level of the drug. Nausea is also one of the first signs of digoxin intoxication. In the evaluation of patients with suspected digoxin intoxication, electrolyte disturbances must be considered because it is the most precipitating factor for digoxin intoxication.

Keywords: nausea, hypomagnesemia, digoxin intoxication, heart failure

PP-14

CAUSES OF ELEVATED PARATHYROID HORMONE LEVELS IN POSTMENOPAUSAL WOMEN

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Aim: In this study we aimed to investigate causes of hyperparathyroidism and related factors in postmenopausal women.

Methods: The study was conducted on 156 postmenopausal women, 43 with normal serum parathyroid hormone levels and 113 with elevated serum parathyroid hormone levels. Serum levels of 25-OH vitamin D, calcium and phosphorus, 24-hour urine calcium, phosphorus and calcium/creatinine ratio were compared between study groups. Also, bone mineral density, age of menopause, educational level, occupation, clothing style, daylight exposure time and daily dietary calcium consumption of subjects and relationships of these parameters with parathyroid hormone levels were investigated.

Results: Cause of elevated serum parathormone level was vitamin D deficiency in 92.9% and primary hyperparathyroidism in 4.4% of study group. Housewives, veiled women, women with education level less than high school found to have statistically significantly elevated parathyroid hormone levels and low vitamin D levels. Statistically significant negative correlation was detected between serum 25-OH vitamin D and the logarithmic value of serum parathyroid hormone levels.

Conclusion: Vitamin D deficiency was common in all postmenopausal women but especially in those with lower education level and the veiled. Postmenopausal women should be screened for vitamin D deficiency and encouraged to benefit more from sunlight. Also, enriching foods in the markets with vitamin D may be helpful for decreasing hyperparathyroidism in this population.

Keywords: Primary hyperparathyroidism, secondary hyperparathyroidism, vitamin D deficiency, postmenopausal women

PP-15

ACHIVED GLYCAEMIC LEVELS AMONG TURKISH OLDER ADULTS WITH DIABETES: REFERENCE TO AGS RECOMMENDATIONS AND MULTIMORBIDITY

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Aim: According to the American Geriatrics Society (AGS) statement in 2012, even among non-older adults, except for long-term reductions in myocardial infarction and mortality with metformin, using medications to achieve glycated hemoglobin (HbA1 c) levels less than 7% is associated with harms, including higher mortality rates. Accor-

ding to AGS recommendations, reasonable glycemic targets would be 7.0–7.5% in healthy older adults with long life expectancy, 7.5–8.0% in those with moderate comorbidity and a life expectancy < 10 years, and 8.0–9.0% in those with multiple morbidities and shorter life expectancy. We here report the distribution of HbA1 c target levels among older adults with diabetes, with special focus on individuals complex and poor health status who are at the risk of potential harms.

Materials and Methods: Men and women aged 65 years or older having diabetes mellitus were enrolled. The percentages of patients with HbA1 c levels £7%, between 7% and 7.5%, 7.5% and 8.0%, 8% and 9.0%, and ≥ 9.0% were determined. Multimorbidity was defined as presence of at least three coexisting chronic illnesses which are conditions serious enough to require medications or lifestyle management as defined by the American Diabetes Association. Patients'health status was classified as "healthy", "complex/intermediate" and "very complex/poor".

Results: The study included 265 patients (mean age: 75.58±6.06) of which 179 were women (75.05±6.05) and 86 were men (76.67±5.98). Mean duration of diabetes was 11.13±9.53 years (1 to 46 years). Mean fasting plasma glucose (136.06±52.25) and glycated hemoglobin (HbA1 c) (6.94±1.61) were correlated (spearman's rho: 0.473, p<0.001). 177 patients (67%) had HbA1 c levels <7%. Other percentages for HbA1 c classifications were as follows: 7%-7.5% : 7.5%, 7.5%-8.0% : 7.5%, 8%-9.0% : 10.2% and ≥ 9.0%: 7.5%. The percent of subjects on metformin alone or in combination was 55.7%, and metformin monotherapy was recorded by 23.5%. Among the subjects with HbA1 c < 7.0% (n=177, 67%) 31.1% were on metformin monotherapy, 26% were on multiple hypoglycemic medications, and 13.6% were on insulin alone or in combination. Among patients with "healthy" status, 18.6% were above target, 18.6% were at target, and 62.6% were below target HbA1 c. Among patients with "complex" health status, 18.34% were above target, 8.3% were at target, and 73.4% were below target HbA1 c. Among patients with "very complex" health status, 9.6% were above target, 9.6% were at target, and 80.77% were below target HbA1 c.

Conclusions: 1) Many patients with diabetes mellitus were found to have lower HbA1 c values than recommended. 2) The results suggest a state of overtreatment of diabetes among Turkish geriatric adults, especially in complex and very complex health status. 3) The study warrants further, shared efforts to increase awareness of reasonable HbA1 c targets for older people among treating physicians.

Keywords: diabetes mellitus, glycemic targets, multimorbidity, overtreatment

PP-16

BLADDER CANCER IN AN ELDERLY PATIENT: A RARE CAUSE OF HYPERCALCEMIA

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Introduction: Hypercalcemia is a high calcium level in the blood serum. The normal range is 8.5–10.5 mg/dL, with levels greater than 10.5 mg/dL defined as hypercalcemia. It is a condition that most commonly associated with malignancy or primary hyperparathyroidism. We present here a case of bladder carcinoma who admitted with hypercalcemia and urinary tract infection.

Case report: A 70-years old male patient was admitted to the Internal Medicine Clinic because of dysuria, exhaustion and loss of appetite. His examination revealed no significant evidence. On the laboratory, calcium level was 14 mg/dl, white blood cell count was 40 000/mm3 and urinalysis showed abundant leucocyte. His parathormone level was suppressed. Firstly, he was accepted as urosepsis and antimicrobial treatment was immediately started along with hypercalcemia treatment including force diuresis and zoledronic acid. At the other side, multipl myeloma and other hematologic malignancies were excluded. His abdomen ultrasonography showed a lesion which has a diameter of 10 cm in the bladder. A transurethral biopsy was performed. The pathologic result was reported as "uroepithelial carcinoma of bladder". On the follow-up, he was transferred to the Intensive Care Unit because of sepsis and he died 10 days later.

Conclusion: With presenting this case, we would like to emphasize that hypercalcemia's differential diagnosis is a though process and all the patients who present with this conditon must be evaluated properly. Treatment for hypercalcemia should be aimed lowering the serum calcium concentration and finding the underlying disease. Effective treatments reduce level of calcium by inhibiting bone resorption, increasing urinary calcium excretion or decreasing intestinal calcium absorption. Up to date, hypercalcemia treatment involves firstly force diuresis and zoledronic acid treatment. Bladder cancer is the most common malignancy involving the urinary system. Urothelial (transitional cell) carcinoma is the predominant histologic type in the United States and Europe, where it accounts for 90 percent of all bladder cancers.

Keywords: hypercalcemia, bladder carcinoma in elderly

PP-17

A RARE LIMITATION OF ANKLE-BRACHIAL INDEX IN AN ELDERLY PATIENT

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Introduction: The ankle-brachial index (ABI) is the ratio of the blood pressure at the ankle to the blood pressure in the upper arm. Compared to the arm, lower blood pressure in the leg is an indication of blocked arteries due to peripheral artery disease (PAD). The ABI is calculated by dividing the systolic blood pressure at the ankle by the systolic blood pressure in the arm. ABI of <0.90 indicates the presence of peripheral arterial disease. But it is not always shows PAD as expected. We present here a very rare and interesting limitation of ABI.

Case report: 76-year-old female patient was admitted to the Internal Medicine Clinic because weight loss, loss of appetite, exhaustion and bilateral leg pain. She lost 20 kg in a year; her leg pain was increased with walking. On the examination, a mass was palpated on the midline of abdomen and right calf and thigh was observed swollen. Bilateral lower limb pulses were not palpated by manual examination. On the laboratory, she had anemia which was compatible with anemia of chronic disease. The lower limb doppler ultrasonography revealed right deep vein thrombosis but no arterial blockage was detected; the bilateral arterial flow was fully normal. On the abdomen imaging with ultrasonography and tomography showed a mass which surrounded the aorta abdominalis. A reduced flow to the lower limbs was showed by doppler ultrasonography of this area. But her ABI measurement was not compatible with PAD (ABI: 1.7). A biopsy was performed fromt this mass and "Diffuse large B-cell lymphoma" was reported. The patient was transferred to the Oncology clinic.

Conclusion: The ABI is the ratio of the highest ankle to brachial artery pressure. An ABI between and including 0.9 and 1.2 considered normal, while a lesser than 0.9 indicates arterial disease. An ABPI value of 1.3 or greater is also considered abnormal, and suggests calcification of the walls of the arteries and incompressible vessels, reflecting severe peripheral vascular disease. The most prevalent limitation for ABI is calcification of vessels. With presenting this case, we would like to emphasize that ABI can not always predict the PAD

and this condition may be relevant a problem which originate from aorta abdominalis associated mass.

Keywords: ankle brachial index, lymphoma, abdominal aorta

PP-18

LEUKOCYTOCLASTIC VASCULITIS IN AN ELDERLY MALE PATIENT

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Introduction: Leukocytoclastic vasculitis (LCV) is a small-vessel vasculitis with a reported incidence rate of about 30 cases per million people per year. The skin is the most commonly involved organ in LCV. The classic presentation is a painful, burning rash predominantly in the lower limbs. We present here a case of LCV in an elderly patient.

Case report: 77-year old male patient was admitted to Internal Medicine Clinic because of newly onset rash on lower extremities and exhaustion. His complaints had been started two weeks ago. On the examination, bilateral painful rash and purpura were observed especially on the lower limbs. On the laboratory, he had anemia of chronic disease and renal failure. The sedimentation rate was 105 mm/h. His ANA, Anti-dsDNA, compleman levels, cryoglobulin levels, lupus anticoagulants and other antiphospholipid syndrome antibodies were all negative. For histologic examination, a skin punch biopsy was performed. The pathologic result was reported as "Leukocytoclastic Vasculitis". The patient was investigated in aspect of malignancies with appropriate imaging and laboratory procedures but no malignancy was identified. Along with these interventions, he was treated with pulse steroid (1 gram methylprednisolone for 3 days), plasmapheresis and IVIG but his renal failure was progressed and he died in Intensive Care Unit 45 days later.

Conclusion: In the evaluation of patients with LCV, laboratory tests including a complete blood count, erythrocyte sedimentation rate, biochemistry profile with liver and renal function, and urinalysis are useful in excluding other vasculitides, determining the presence of systemic disease, and identifying an associated disorder, which can provide prognostic information. With presenting this case, we would like to emphasize that LCV can be rapidly progressive nature in an elderly patient so The appropriate interventions should be carried out without delay.

Keywords: Leukocytoclastic vasculitis

PP-19

THERE ARE STILL DEBATES ABAOUT BREAST SELF EXAMINATION, BUT?

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Introduction: Breast self-examination is a screening method used in an attempt to detect early breast cancer. The method involves the woman herself looking at and feeling each breast for possible lumps, distortions or swelling. We present here a case of invasive ductal breast cancer in a 86 year old woman who examined herself and detected a mass in the right breast at early disease phase.

Case report: 86 year-old woman was admitted to he Internal Medicine Clinic because of a mass in the right breast. She had no complaints about this mass including discharge from the nipple, pain or hyperemia. She had noticed this mass a week ago on self breast examination. On the examination, the mass which had a diameter of 2x2 cm; immobile and firm character, was palpated. She had no axillary lymphadenopathy or left breast mass. On the laboratory, she had no abnormal value. The mass was reported as BI-RADS 4C on the mammography. The malignancy potential was confirmed by breast ultrasonography. A biopsy was performed and "invasive ductal carcinoma" was reported. She transferred to the surgery department.

Conclusion: There are still debates about self breast examination. Many society recommend against the use of breast self-examinations because it is considered as not effective in preventing death, and actually caused harm through needless biopsies, surgery, and anxiety. But in this case, the patient noticed a mass thanks to her self examination and she was treated in the early phase of disease.

Keywords: breast self-examination, invasive ductal carcinoma

PP-21

HODGKIN LYMPHOMA IN AN ELDERLY PATIENT

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Introduction: Hodgkin lymphoma arises from germinal center or post-germinal center B cells. Symptoms may include fever, night sweats, and weight loss. Often there will be enlarged lymph nodes in the neck, under the arm, or in the groin. We present a case of Hodgkin lymphoma who was admitted with night sweats and weight loss.

Case report: 83-year-old woman was admitted to the Internal Medicine Clinic because of night sweats and weight loss. She had lost 20 kg and had night sweats in a year. On examination, a lymphadenopathy was palpated at the anterior cervical area of the neck which had a firm and immobile character. No other significant finding was observed on the examination. She had high sedimentation rate and anemia of chronic disease on the laboratory. TORCH markers and the other serologic and infectious markers were all negative. Neck ultrasonography showed that the lymphadenopathy could have a malignancy potential. Because of this, a biopsy was performed and Hodgkin Lymphoma was reported. She was transferred to the Hematology Clinic.

Conclusion: Hodgkin's lymphoma must be distinguished from non-cancerous causes of lymph node swelling (such as various infections) and from other types of cancer. Definitive diagnosis is by lymph node biopsy. Unlike some other lymphomas, whose incidence increases with age, Hodgkin's lymphoma has a bimodal incidence curve; that is, it occurs most frequently in two separate age groups, the first being young adulthood (age 15–35) and the second being in those over 55 years old although these peaks may vary slightly with nationality. With presenting this case, we would like to emphasize that this disease can be seen in elderly patient group and can be treated safely.

Keywords: hodgkin lymphoma, night sweats, weight loss

PP-22

CASTLEMAN DISEASE IN AN ELDERLY PATIENT

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Introduction: Castleman disease (CD) is a rare disease of lymph nodes and related tissues. It is a heterogenous group of lymphoprolif-

erative disorders that are sometimes associated with human immunodeficiency virus (HIV) and human herpesvirus 8 (HHV-8). The exact cause of Castleman disease is unknown. An increased production of IL-6 by lymph nodes appears to have a role in the development of Castleman disease. We present here a case of Castleman disease who presented with weight loss and night sweats.

Case report: 68-year-old mad was admitted to the Internal Medicine Clinic because of night sweats and weight loss. He had lost 14 kg and had night sweats in a year. On examination, multipl lymphadenopathies were palpated at the anterior cervical area of the neck which had a firm and immobile character and had a greater dimension 3 x 3 cm. He had high sedimentation rate (>100 mm/h) and anemia of chronic disease on the laboratory. TORCH markers and the other serologic and infectious markers (include HIV) were all negative. Neck ultrasonography showed that the lymphadenopathy could have a malignancy potential. Because of this, a biopsy was performed and Multicentric Castleman disease was diagnosed. He was transferred to the Oncology Clinic.

Conclusion: Castleman disease (CD) is characterized by nodal expansions that usually leave the structure of the underlying lymph node at least partially intact. B cells and plasma cells are polyclonal, and T cells show no evidence of an aberrant immunophenotype. It can be divided to separated groups as localized and multicentric Castleman disease. Castleman disease is rare. It has no apparent sexual predilection and affects people of all ages, although it appears to be rare in children. The mean age of patients with MCD is 50–65 years. Persons with HIV infection may be younger. The prognosis of Castleman disease varies based on the type. Multicentric Castleman disease has a variable prognosis, from indolent disease to an episodic relapsing form to a rapidly progressive form leading to death within weeks.

Keywords: castleman disease

PP-23

CLOSE ENOUGH TO REACH WITH YOUR HANDS: A CASE WITH ANAPLASTIC THYROID CARCINOMA

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Introduction: Anaplastic thyroid carcinoma, originating from the thyroid epithelium, is a rare cancer that is often seen in the 6th and 7th decades with a female-male ratio 3/1. Unlike other thyroid cancers, it is rapidly progressive and almost fatal. It has a median survival 3–9 months and overall survival over 3 years is below 10%. As it is usually locally advanced at the time of diagnosis with concomitant pulmonary metastasis in half of the cases.

Case Presentation: A 74-year-old female patient admitted to another health institution where metastatic lesions were detected in HRCT, with complaints of productive cough, malaise and loss of appetite. Then the patient was admitted to our clinic with the aim of investigating primary malignancy. Her overall general condition was bad and physical examination revealed a 5–6 cm sized firm and nodular mass in the right lobe of thyroid gland and wheezing. Multiple bilateral breast masses, the largest one about three centimeters, were palpable in the medial side and lower outer quadrant of the right breast. Elevated erythrocyte sedimentation rate, CRP and LDH were detected in the laboratory study. Erosive gastritis was detected on endoscopy by evaluating that lesions on chest X-ray and thorax tomography may be metastasis of primary GIS malignancies. The patient could not take a colonoscopy. The masses in the breast were reported as BRAIDS-2. Anaplastic thyroid carcinoma was defined by thyroid fine needle aspiration biopsy made with the strong suspicion of malignancy. The patient was referred to the oncology clinic in terms of chemotherapy and radiotherapy.

Conclusion

There are two features that make our case worth sharing. First is to review literature and help determine our priorities in anaplastic thyroid cancer which is quite rare with increased healthcare access. Like in our cases with metastatic disease, securing the airway and ensuring access for nutritional support should be a priority treatment approach through combined radiotherapy and chemotherapy. Secondly; to emphasize the fact that detailed physical examination-gradually lost its importance, unfortunately-can be life-saving for diseases in which early diagnosis and treatment are indispensable.

Keywords: Anaplastic thyroid carcinoma, physical examination, radiotherapy and chemotherapy, thyroid cancers

PP-24

AGE AT FIRST OSTEOPOROSIS SCREENING AMONG OLDER TURKISH WOMEN AND MEN: IS BMD MEASUREMENT ORDERED TIMELY?

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Lumbar and hip bone mineral density (BMD) measurement by DXA is the standard, guideline recommended tool for osteoporosis screening. US National Osteoporosis Foundation (NOF) recommends screening of osteoporosis by quality assured DXA in women aged 65 and men 70 years or older, regardless of existing other risk factors. Proactive or delayed ordering of first BMD measurement is a common issue. We investigated in the present study whether Turkish seniors undergo their first ever BMD measurement early, on time or late.

Materials and Methods: Women and men aged 65 years or older were included. Personal history of age at a previous, first ever BMD testing was determined. Patients'report of the result of this index BMD testing was recorded as history of osteoporosis present or absent. The status of having been screened was recorded "late" when women older than 65, and men older than 70 years of age had no history of BMD testing at the time of inclusion. "Early" screening was defined as having been screened before these age definitions.

Results: The study included 481 individuals (mean age: 74.5±6.6). There were 299 women (mean age: 73.9±6.5) and 182 men (mean age: 75.5±6.6). No definite history of prior BMD testing or diagnosis of osteoporosis was available for 86 (17.9%) participants. History of a BMD testing before the time of admission was present in 227 (47.2%) individuals, while 168 (% 34.9) subjects had no BMD testing. Among the subjects with a past BMD measurement (n=227), 147 (% 64.8) reported previous diagnosis of osteoporosis, 75 (% 33) reported absence of osteoporosis, and 5 (% 2.2) were not sure of the result. Mean age of reported first BMD measurement was 67.1±8.0 for women, and 69.2±5.5 for men. Among women at the age of 65 or older, 27.2% (74/272); among men at the age of 70 or older 77.5% (86/111) had no previous BMD testing. When only the age criterion was taken into account, 35.9% (71/198) of women, and 48.3% (14/29) of men were screened early; 9.6% (19/198) of women, and 10.3% (3/29) of men were screened timely; and, 54.5% (108/198) of women, and 41.4% (12/29) of men were screened late. History

of osteoporotic fractures was recorded by 34.1%, 51.2% and 14.6% among those with early, late or timely screening, respectively.

Conclusions: 1) One out of 6 older adults were not able to give sufficient information of past osteoporosis screening or diagnosis. 2) Almost 65% frequency of osteoporosis personal history far exceeds the true prevalence of the disease. 3) Three out of 10 women and 4 men were found unscreened despite presence of single indication by age. 3) One out of 3 women and 2 men reported early, and 1 of 2 women and 2 out of 5 men reported late screening. 4) Subjects with a late screening history had the highest percentage of osteoporotic fractures.

Keywords: bone mineral density, osteoporosis, screening

PP-25

IS THE SUN ALWAYS RISING FROM THE EAST: A CASE WITH ATYPICAL PRESENTATION OF ACHALASIA

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Introduction: Achalasia is an uncommon condition with an annual incidence 1.2 per 100 000. It results in degeneration of the myenteric nerve plexus of the esophageal wall progressively but the etiology is unknown. Loss of esophageal peristalsis and failure of relaxation of the lower esophageal sphincter are the characteristics of achalasia. Although dysphagia, regurgitation and chest pain are more common and usual for achalasia, it can be present with atypical conditions, such as aspiration pneumonia, lung abscess and cancer.

Case Presentation: A 77-year-old male patient followed up with ischemic heart disease, diabetes and hypertension was admitted to the hospital with complaints of fever, fatigue, cough especially after feeding and difficulty in swallowing during the last 10 days. The patient was reported to have had an ischemic cerebrovascular event a year ago. Physical examination revealed reduced skin turgor tone and fever. Leukocytosis, elevated erythrocyte sedimentation rate and CRP were detected in the laboratory study. Aspiration pneumonia was considered predominantly by reason of nutrition-related cough, cerebrovascular event history and infectious markers so the diagnosis was confirmed by HRCT and IV antibiotic therapy was initiated promptly. But excessively enlarged esophagus was observed in the imaging. The endoscopy on which it was found that the distally of the esophagus has become too narrow and the body of esophagus has enlarged containing undigested food. Oral intake has been stopped and fed by nasogastric tube for a while. After confirmation of the diagnosis of achalasia with the manometry study endoscopic balloon dilatation was performed. The patient was finally discharged after improvement of symptoms.

Conclusion: The cause of symptoms and findings in achalasia is the relaxation defect in the lower esophagus sphincter (LES). This pathology can be overcome by mechanical disruption of LES or reducing the pressure of the LES with nitrate, calcium channel blocker, botulinum toxin. Endoscopic pneumatic dilatation and surgical myotomy are more effective in terms of success than other treatment modalities. Recently, per oral endoscopic myotomy has emerged as a promising technique in patients do not respond well to conventional therapies and in one who failed prior endoscopic and surgical treatments. Finally it should be kept in mind that in patients presenting with aspiration pneumonia, the condition may be not only related to old age, swallowing difficulty or dementia, but also serious and manageable organic pathologies such as achalasia.

Keywords: Achalasia, Endoscopic pneumatic dilatation, Aspiration pneumonia

PP-26

ASSESSING ELDERLY PATIENTS IN A NEUROLOGY PRACTICE FOR RISK OF FALLS

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Objective: Falling, individuals any pushing force, without any faint or stroke, carelessness result become less active from the level that individual was. In this study we seek to find falling rist level valuation geriatric inpatients whom stay in neurology clinic.

Material and Methods: This prospective and descriptive work consisted of fifty patients admitted to the Neurology Clinic of a university hospital between June and August 2015. When patients are in the clinic they completed a survey which informs patient's individual abilities and another test called Hendrich II Falling Risk Valuation and Monitoring form. According to the Hendrich II Fall Risk Assessment and Monitoring Form, 0–4 low risk, > 5 high risk. The answers of the questions such as age, gender, education level, diagnosis, presence of falling story in last 3 months, presence of visual problem, attendant status, use of support during walking, presence of postural instability, The risk of falling was assessed using the IBM SPSS Statistics Version 20.0 package program. Categorical measures were summarized as number and percentage, mean and standard deviation in numerical measurements, Chi square test statistic in comparison of categorical measurements between groups, and T test in independent groups in comparison of age values between groups. The statistical value level was taken as 0.05 in all tests.

Results: The avarage age of the patients is 72.2 ± 6.0, the avarage age of the women is 72.02 ± 6.1, and the avarage age of the male is 72 ± 6.3 years. Thirty patients (60%) were male and 20 (40%) were female. Patients 6 (12%) were non-literate, 2 (4%) of them literate, 14 (28%) of primary school, 5 (10%) secondary education, 23 (46%) were university graduates. In 12 of the patients had a history of falling in the last 3 months. 28 (56%) patients had vision problems, 15 (30%) patients use of support when walking, 45 (90%) patients stay in hospital with companion. The most frequent dropping place and time was 74% in the bath and between 08–16 hours and 50% had postural instability. There was no statistical significance between Hendrich II Fall Risk score and age, gender, educational level, diagnosis of neurological disease, existence of the story of fall in the last three months, presence of vision problem, presence of companion, place and time. However, statistical significance was found between postural instability and walking support use. ($P < 0.001$ and < 0.000 respectively).

Conclusion: When 65 years of age and above are admitted to the hospital evaluated in terms of the risk of falling Hendrich II Fall Risk Assessment and Monitoring Form must be filled in, for those at high risk, at the time of hospital stay and later in life the patient and his/her relatives should be informed about the subject by taking necessary precautions.

Keywords: elderly, fall, neurology, risk

PP-27

SAY NO TO AGEISM: THE ADVENTURE OF A GERIATRIC PATIENT

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Background: Geriatric Medicine is a science that provides comprehensive assessments (GCA) that serve the different needs of the elderly such as malnutrition, sarcopenia, functional independence, cognitive impairment, polypharmacy, ageism. One of the problems that older people are experiencing is ageism. Ageism usually refers to negative discriminatory practices against old people. This negative approach is also seen in the health sector. This is a story of a patient who has lost her life with complications of aggresive B-cell lymphoma (ABCL). The diagnosis is delayed because it is not examined in time as a result of ageism.

Case: An 83-year-old female patient was referred to emergency department with fatigue and fever. Previously she had a recurring emergency application within 15 days at the foreign centers. However, she was followed up with symptomatic treatment in emergency service. The patient has never been examined further. After 15 days, she was admitted to the internal medicine clinic with fever unknown origin (FUO). The patient was referred to the emergency department of our hospital upon deepening of the anemia. The results of laboratory tests are shown in Table 1. The patient was also consulted in the hematology department, but follow continued in the emergency. The patient was admitted for further examination. It was learned that patients and her relatives did not accept lumbal punching for cerebrospinal fluid sample and bone marrow biopsy (BMB) in the emergency department. Neck-thoracoabdominal CT was performed for malignancy investigation. Splenomegaly, spleen infarcts, bilateral pleural effusion were detected. BMB was recommended again for anemia and thrombocytopenia which continued and deepened despite replacement. Pleural effusion sampling was suggested. However, patients relatives did not accept both tests. Many antibiotics were used because of FUO. However, the response to the treatment was not received. BMB were performed with relatives of patients approving the BMB, approximately 9 days after being recommended. But the patient had died due to sepsis before pathology results end. BMB pathology result was reported as ABCL after she has died. Despite the fact that the patient has died, the diagnosis information was sent to her relatives.

Result: A fever that can not be explained and does not respond to symptomatic treatment is a condition that needs to be investigated rapidly. In our case, it is seen that because of the negative attitudes of both health sector employees and patient relatives, the examinations were delayed. Elderly patients are exposed to negative prejudices of many departments because of their multiple comorbidities. This case demonstrates the importance of the CGA of the elderly and the extension of the science of geriatrics, where the examination is made. CGA should be performed by all medical disciplines, including emergency departments. Only with this way, ageism and aged neglect may decrease over time.

Keywords: ageism, elderly, fever

Table 1. Laboratory Results

	Results	*Normal Range*
Blood Urea Nitrogen (BUN)	11 mg/dL	8–23
Creatinine	0.47 mg/dL	0.5–1.1
Sodium (Na)	141 mEq/L	136–145
Potassium (K)	3.5 mEq/L	3.5–5.1
Calcium (Ca)	6.5 mg/dL	8.7–10.4
Total Protein	4.5 g/dL	5.7–8.2
Albumin	2.2 g/dL	3.2–4.8
Aspartate Aminotransferase (AST)	38 U/L	< 34
Gama Glutamil Transferaz (GGT)	43 U/L	< 38
Alkaline Phosphatase (ALP)	93 U/L	45–129
Lactate Dehydrogenase (LDH)	530 U/L	120–246
Leukocyte (WBC)	6.31 x10^9/L	4.5–11
Erythrocyte (RBC)	3.21 x10^12/L	3.8–5.2
Platelet (PLT)	85 x10^9/L	150–400
Hemoglobin (Hb)	9.1 g/dL	11.7–16.1
Hematocrit	27.8	% 35–47
Mean Erythrocyte Volume (MCV)	86.6 fL	81–102
Neutrophils Count	3.37 x10^9/L	1.8–7.7
Lymphocyte Count	0.74 x10^9/L	1.5–4
Monocytes Count	2.12 x10^9/L	0.2–0.95
CRP	161.1 mg/L	0.0–5.0
CMV-DNA, Parvovirus B19, EBV-VCA IG, Herpes type 1 and 2 antibodies, Brucella antigen and immunoglobulin, ANA, ANCA, serum protein electrophoresis, urine culture, coombs and herpes immununglobulins for FUO. The all results were normal.		

PP-28

TWO CLASSIC KAPOSI SARCOMA CASE IN ELDERLY

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Background: Kaposi sarcoma (KS) is an angioproliferative disease caused by HHV-8 infection and orginating from vascular and lymphatic endothelium. Classified in 4 subtypes: classic (the type originally described by Kaposi, which typically presents in middle or old age), endemic, iatrogenic (a type associated with immunosuppressive drug therapy, typically seen in renal allograft recipients) and AIDS-associated. We present examples of classic type KS, especially seen in the distal lower extremity. That type of KS is usually indolent; rarely aggressive and disseminated and visceral involvement is uncommon. It is more frequent in elderly and 3 times more common in males.

Case-1:83 years-old, female patient had hypertansion (HT), diabetes mellitüs (DM), Congestive Heart Failure (CHF), Coroner Artery Disease (CAD), Chronic Kidney Disease (CKD) and Uveal malignant melanoma (MM). She was admitted to our clinic with shortness of breath, pretibial edema and foot rash. In her anamnesis, MM was diagnosed 1.5 years ago and she received 3 times Cyberknife RT treatment to uveal area. In laboratory results, there was no pathology except for GFR reduction and chronic disease anemia because of CKD. On physical examination, bilateral nodular-erythematous lesions and +/+ pretibial edema were detected in the lower extremity. Dermatology was consulted for the cause of skin lesions. Skin biopsy was obtained with the diagnosis of KS? or MM? Pathology result: Kaposi

Sarcoma was reported as tumor-free surgical margins at the tumor stage. PET-CT scans for metastases. Metastasis was not detected and dermatology control was recommended for her follow-up.

Case-2:73 years-old male patient with known DM, HT, Alzheimer's Disease and Parkinson's Disease applied for general control. Laboratory values: no pathology was found. In addition to the evaluation and treatment of the patient for other diseases, purple plaques on the basis of on both feet was found in the physical examination. It was thought that the skin lesions of the patient could be KS. Dermatology was consulted for skin biopsy. Because of purple-plated color change, lower extremity doppler was performed to exclude arterial thrombosis. No pathology other than focal stenosis in the dorsalis pedis artery, intense atherosclerosis and vascular calcification was found in the left arterial system. Skin biopsy pathology result: 1. Kaposi Sarcoma (patch period) 2. Kaposi Sarcoma (tumoral period) the tumor. Thoracic-abdominopelvic CT was used for metastases scan. No pathology was found except for non-specific millimetric nodules in the lung. The patient was given palliative radiotherapy. Follow-up by dermatology continues.

Results: Skin lesions in the elderly can be confused with many diseases. Skin cancer should be considered with increasing age, and a detailed skin examination should be performed on routine physical examination in elderly. Biopsies should be requested from the lesions that are seen as specific.

Keywords: Classic Kaposi Sarcoma, Elderly, Skin Examination on routine physical examination

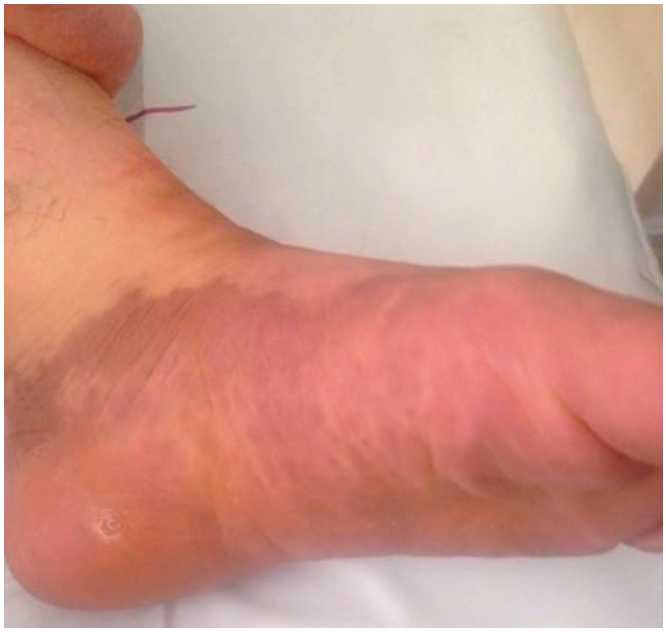

Figure 1.

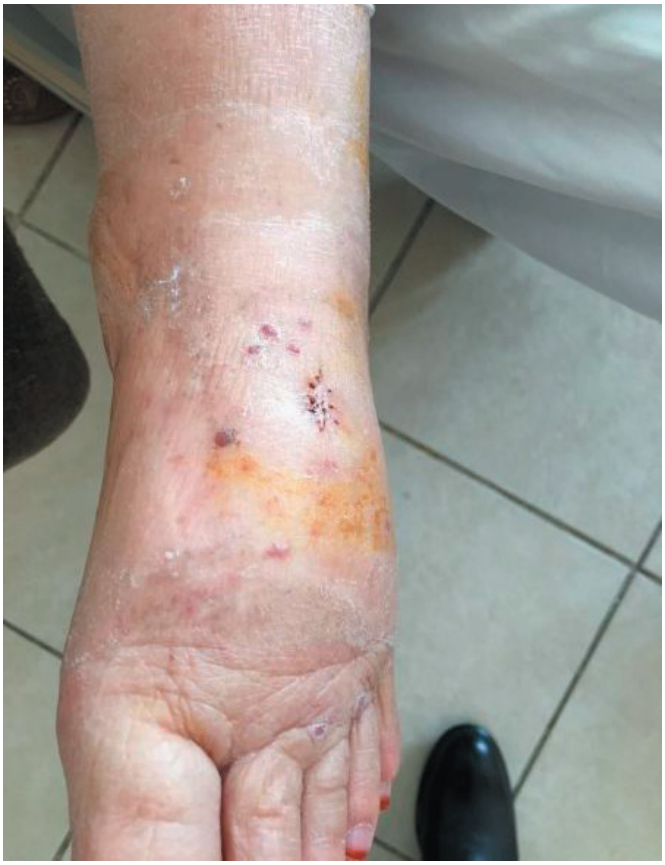

Figure 2.

PP-29

AN OLDER BURKITT'S LYMPHOMA CASE WITH ATYPICAL PRESENTATION

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Introduction: Burkitt lymphoma (BL) is a highly aggressive B-cell non-Hodgkin lymphoma characterized by the translocation and deregulation of the *c-myc* gene on chromosome 8 (1). Three distinct forms of Burkitt lymphoma are identified; endemic (African), sporadic, and immunodeficiency-associated subtypes.

Case: 86 years old female patient has been followed in our geriatrics clinic with history of hypertension, hyperlipidemia and aortic stenosis. After eating strawberries, she was admitted to the emergency department after swelling in her mouth and lips, her body was itchy, and was directed to the geriatric polyclinic with antihistaminic treatment. A physical examination revealed 3/6 systolic murmur and reducible umbilical hernia on admission to hospital. Patient was recommended for further evaluation because of high sedimentation rate and CRP and there was no evidence of clinically suspected infection. The patient was admitted to the hematology clinic due to fatigue from time to time and abdominal computed tomography revealed 27 * 17 mm hypoechoic solid formation in the liver, multiple lymphadenopathies in the mesentery, and significant hyperplasia in the endometrium. Existing radiological findings were consultated with gynecolog-

ical and obstetric departments and then radiological ablation of the liver was performed during the operation of hysterectomy + bilateral salpingo-oophorectomy.

In July 2016-post-operative 25th day, she applied to the geriatric policlinic again with complaints of fatigue and 39 degrees fever at nights falling with nonsteroid antiinflamatuary drug, and admitted to our clinic. In the meantime, it was seen that the pathological result of the operation was atrophic endometrium, tuba and ovaries without significant pathology. Newly taken abdominal CT of the patient showed hypoechoic lesion in the liver which is previously seen, lymph nodes and thickening of the cecum. Gastroscopy, colonoscopy and positron emission tomography (PET) CT for primary tumor detection were performed. Patient's abdominal PET-CT image is added. Gastroscopy and colonoscopy was normal, but PET scan showed showed increased pathologic metabolism in the multiple lymph node, which is very common in the abdomen and mediastinum, is suspected to be a lymphoma. The mesenteric lymphadenopathy biopsy was consistent with EBV-associated Burkitt's lymphoma. The patient was referred to hematology for further treatment.

Discussion: Approximately 60% of all new cases of cancer and 70% of all cancer-related deaths occur in the elderly population, defined as comprising individuals aged ≥ 65 years (2). She was operated without biopsy diagnosis by considering the primary endometrium Ca because of the report of endometrium hyperplasia in the imaging. This case shows that even an aggressive lymphoma like BL can show different presentation in the elderly and comprehensive geriatric assessment should be performed by other diciplines not only geriatrics.

Keywords: older, atytpical presentation, lymphoma

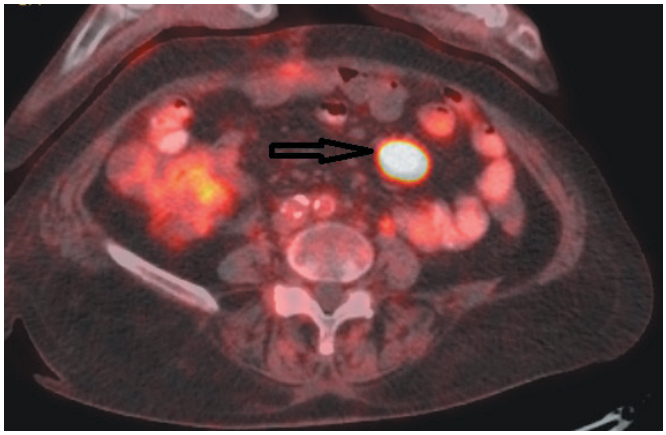

Figure 1.

Tablo 1. Abnormal laboratory values of patient

Uric Ascite	7.8 mg/dL
LDL-cholesterol	191 mg/dl
Sedimantation	76 mm/h
CRP	19.7 mg/L
Hemoglobin	11.6 g/dL
Lymphocyte	0.99 x10^9/L
25-Hydroxy Vitamin D	5.25 µg/L
Mean corpuscular volume (MCV)	93.8 fL

PP-30

EXAMINATION OF TWO IMPORTANT ISSUES OVER AN OLDER PATIENT; PROSTATE CANCER SCREENING AND INFECTIVE ENDOCARDITIS

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Prostate cancer is the second most common cancer in men in our country according to the United Databank of Turkey, between 2006 and 2010 but mortality rate is more less.

Case: 77 years old male patient has been followed in our geriatrics clinic with history of hypertension, benign prostat hypertrophy, transient ischemic attack and chronic obstructive pulmonary disease. The patient applied to the geriatrics policlinic with complaints of fatigue, pollacuria, nocturia and dysuria. The prostate-specific antigen (PSA) was 16.01 ng/mL. There was Enteroccocus faecalis as a result of urine culture, oral levofloxacin was started. When he was on antibiotherapy, ultrasonography-guided needle biopsy of prostate was performed on admission to the urology department due to sudden globe vesicle. 1 month later after prostate biopsy, he applied to the geriatric polyclinic with complaints of fatigue, severe back pain, fever and he admitted to our clinic. On physical examination murmur was detected in mitral focus. Enteroccocus faecalis occurred 4 times in the blood culture taken during the fever. Echocardiography (ECO) was performed because of new developing murmur; left atrial size was large, aortic valves were slightly thicker, prolapse with proliferation of tissue in mitral anterior lobe and 2–3. degree mitral insufficiency was observed. There was any microorganism in blood and urine culture after 14 days levofloksasin therapy and he discharged from hospital.

Two months later he was admitted to the hospital due to fever and severe back pain. Enterococcus faecalis was seen in blood culture, ampicillin 4 * 1 gr iv was started. Thoracic and abdominal CT for waist and abdominal pain were taken and there were abscess on anterior paravertebral region at L3–4 level and on the right psoas muscle. Spondylodiscitis was detected in the same vertebral corpus and operation planned. In the ECO, which was made for preoperative evaluation, vegetation of 1.4x0.9 cm in diameter with wide placement on the valve was determined. Vegetations on ECO image and spondylodiscitis image on abdominal CT are added. Gentamycin and ampicillin treatment were given for 6 weeks for infective endocarditis. After 6 weeks of antibiotherapy, control ECO was performed and valve flap operation was recommended for continuing vegetations but the patient did not admit operation. 3 months later from discharging from hospital; there were prolapsus and calcification of 1.2x0.8 cm in diameter on the mitral anterior leaflet. The patient is being followed in our clinic.

Conclusion: In American Urological Association guideline; it is not recommended routine PSA screening in men over age 70 years or any man with less than a 10 to 15 year life expectancy. In our case; prostate biopsy was performed within right indication but patient has been exposed to serious complications because of biopsy. The variety and seriousness of expected complications due to screening for asymptomatic persons should be considered.

Keywords: infective endocarditis, prostate cancer, older

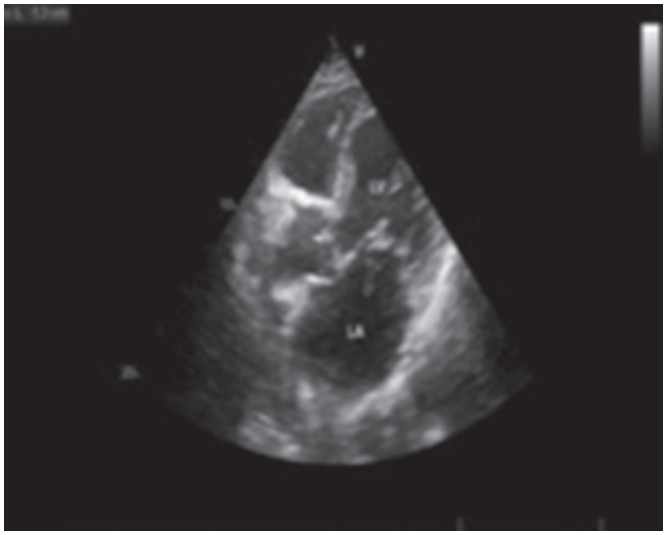

Figure 1.

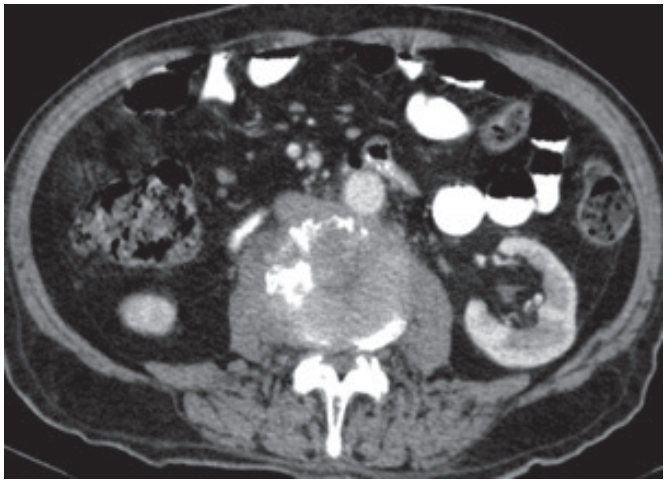

Figure 2.

PP-31

CLINICAL PREDICTORS ON MORTALITY IN OLDERS WITH ACUTE VENOUS THROMBOEMBOLISM; 10 YEARS EXPERIENCE

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Aim: We aimed to investigate the mortality rate, survival and factors affecting acute thromboembolism in elderly patients in our geriatric clinic for 10 years.

Materials and Methods: Forty-eight patients who were hospitalized due to acute thromboembolism or developed acute thromboembolism during admission for another reason at Ankara University Geriatrics Clinic between 2006 and 2016 were retrospectively screened.

Results: 35 were female (73%) and 13 were male (27%) of the patients. Mean age was 83 (min. 69-max. 98) and mean D-dimer was 1800 ng/ml (min. 330-max. 29000). 26 patients had deep vein thrombosis (DVT), 12 had post-DVT pulmonary thromboembolism (PTE), 7 had PTE and 3 had other sites of embolism. There were polypharmacy in 16 patients (33%). 11 patients (23%) were using anti-aggregan before embolism. 27 patients (56%) were immobilized, and 10 patients (20%) had malignancy. 7 patients (15%) had recurrent DVT. The average hospital stay was 17 days. At the end of 10 years follow-up, 36 (75%) patients died and the median overall survival time was 18 months (95% GA 2.1–33.8). Overall 1-year survival rate was 58%. In univariate analysis, parenteral anticoagulant use, neutrophil lymphocyte ratio (NLR) and vitamin D level were associated with survival. As the levels of NLR and vitamin D increase, the risk of death increases. Survival was significantly lower in the NLR> 5.9 group. Hazard ratio was 2.25 for anticoagulant use, death risk was 2.25 times higher in patients using parenteral anticoagulants.

Conclusion: The incidence of venous thromboembolism increases sharply with age, with 27 cases per 100.000 person-years in persons aged 40 years to 410 cases in those aged 65 years (1). The elderly not only have a higher incidence of venous thromboembolism but also have an approximately 2-fold increase in major bleeding and 2 to 3 fold greater risk of all-cause mortality over time than younger patients (2). Despite the higher morbidity and mortality, venous thromboembolism remains understudied in the elderly (2). As we know, our study is the longest follow-up study of acute thromboembolism in elderly patients in hospital.

References

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Keywords: venous thromboembolism, mortality, older

Table 1.

	p	Hazard Ratio	95,0% CI for Exp(B)	
			Lower	Upper
GENDER	,401	1,39	,645	2,993
AGE	,402	1,02	,972	1,074
HOSPITAL STAY	,104	0,97	,931	1,007
DVT	,949	0,97	,423	2,240
PTE	,739	1,13	,557	2,282
POLIPHARMACY	,463	1,29	,652	2,562
ANTIAGGREGAN	,994	1,00	,470	2,140
ANTICOAGULATION(DMAH)	**,018**	**2,25**	**1,148**	**4,403**
D_DIMER	,061	1,00	1,000	1,000
HB	,976	1,00	,841	1,195
LOKOSYTE	,485	1,00	1,000	1,000
PLATELET	,305	1,00	1,000	1,000
N/L RATIO	**,005**	**1,23**	**1,063**	**1,426**
LDH	,137	1,00	1,000	1,002
ALBUMIN	,248	0,77	,503	1,194
CRP/ALB	,172	1,01	,997	1,015
DVIT	**,042**	**1,03**	**1,001**	**1,068**
TSH	,281	0,99	,963	1,011
MALIGNITY	,286	1,54	,696	3,414
IMMOBILISATION	,640	0,85	,438	1,661

PP-32

IS THERE AN ASSOCIATION BETWEEN PEPTIC ULCER AND 25-HYDROXY VITAMIN D IN THE ELDERLY?

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Purpose: Vitamin D deficiency is a major public health problem that is widespread in our country and in the world. Vitamin D is related to calcium absorption from the gastrointestinal tract and kidney. As vitamin D levels increase, calcium absorption increases and blood calcium levels rise. Because calcium has a role in gastrin release, it is thought that hypercalcemia causes peptic ulcer. In this study, we aimed to demonstrate the possible association between vitamin D levels and peptic ulcer; based on the hypothesis that the increase in vitamin D levels may increase the blood calcium and the risk of peptic ulcer, even without hypercalcemia.

Materials and methods: 400 patients who underwent endoscopy at our service were retrospectively reviewed. Patients who had undergone gastric surgery, were taking vitamin D supplementation, had lack of knowledge were left out of the study and 240 patients (85 males vs. 155 females) remained. They were divided in two groups as peptic ulcer (+) and peptic ulcer (-). 25-(OH) vitamin D, calcium, phosphate and parathormone levels were compared. Also patients were divided in 4 groups according to 25-(OH) vitamin D levels that; very low (<10 ng/ml), low (10–20 ng/ml), insufficient (20–30 ng/ml), normal (> 30 ng/ml) and these groups were compared in terms of peptic ulcer percentage.

Results: The mean age of the participants were 79.2 and there were no significant difference between the two groups (78.9 vs. 79.3). When the two groups were compared 25-(OH) vitamin D levels were found higher in non-peptic ulcer group but this was not statistically significant (17.3 ng/ml vs. 15.3 ng/ml). In addition; BUN, creatinine, calcium, phosphate and parathormone levels were not significantly different between the two groups (table 1). When the patients were compared according to their 25-(OH) vitamin D levels, low group (10–20 ng/ml) was found to have the lowest ulcer rate (n: 45, 89.4% vs. 10.6%) (table 2).

Conclusion: Vitamin D deficiency is a public health problem that affects whole population, especially the geriatric population due to osteoporosis and osteomalacia; also vitamin D deficiency is thought to affect many metabolisms besides bone metabolism. In this study, we investigated whether there is a relationship between vitamin D deficiency and peptic ulcer. According to our study, there was no difference between the 25-(OH) vitamin D levels of two groups. On the other hand, we concluded that peptic ulcer is less common in the group with vitamin D levels of 10–20 ng/ml. These results did not support our hypothesis and showed that vitamin D did not play a role in peptic ulcer formation. As a result, our findings need to be supported by more comprehensive studies.

Keywords: 25-(OH) vitamin D, peptic ulcer, vitamin D deficiency

Table 1. Comparison of mean values of findings in two groups (MNA: mini nutritional assessment; Ns: not significant)

	Peptic ulcer (-) (N: 199)	*Peptic ulcer (+) (N: 41)*	
	Mean±SD	*Mean±SD*	*P value*
Age	79.39±7.66	78.80±7.27	Ns
Lawton-Brody	10.94±6.36	10.27±6.65	Ns
Katz	5.09±1.63	4.82±1.78	Ns
BUN	19.73±9.94 mg/dl	21.68±9.24 mg/dl	Ns
Creatinine	1.01±0.48 mg/dl	1.09±0.50 mg/dl	Ns
Calcium	9.49±0.48 mg/dl	9.59±0.63 mg/dl	Ns
Albumin	3.53±0.59 g/dl	3.29±0.61 g/dl	Ns
Phosphate	3.59±0.68 mg/dl	3.64±0.57 mg/dl	Ns
25-(OH) vitamin D	17.36±13.73 ng/ml	15.36±11.16 ng/ml	Ns
Parathormone	72.63±86.47 pg/ml	88.46±96.71 pg/ml	Ns

Table 2. Peptic ulcer percentages according to 25-(OH) vitamin D levels

	Peptic ulcer (-)	*Peptic ulcer (+)*
<10 ng/ml	78.4% (N: 76)	21.6% (N: 21)
10–20 ng/ml	89.4% (N: 59)	10.6% (N: 7)
20–30 ng/ml	82.2% (N: 37)	17.8% (N: 8)
>30 ng/ml	84.4% (N: 27)	15.6% (N: 5)
Total	82.9% (N: 199)	17.1% (N: 41)

PP-33

A CASE OF NONALBUMINURIC DIABETIC RENAL INSUFFICIENCY: IS IT A NOVEL CATEGORY OF DIABETIC NEPHROPATHY?

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Introductıon: Albuminuria is regarded as an important biomarker to detect early phase diabetic nephropathy. Diabetic nephropathy is classified into five categories; however, it does not always progress from one category to the other sequentially. Some diabetic patients may present with a decreased estimated glomerular filtration rate (eGFR) without albuminuria. Here, we present a patient who had pathologically confirmed diabetic nephropathy without microalbuminuria.

Case presentatıon: A 65-year-old female presented with fatigue, nausea, swollen legs, pain and numbness in the fingers and toes. Her medical history was significant for hypertension and hyperlipidemia for 30 years, diabetes for 15 years, Sjögren syndrome for two years, and coronary artery disease for which a balloon angioplasty had been performed. At the time of admission, her medications included candesartan, metoprolol, doxazosin, pravastatin sodium, acetyl salicylic acid, hydroxychloroquine, metformin, 30% insulin aspart and 70% protamine-crystallised insulin aspart combination. Her HbA1 c level was 9.8%, and she was hospitalized for uncontrolled diabetes mellitus. Her creatinine level was increased to 2.35 mg/dL. She had an anemia of chronic disease and her laboratory results were within normal limits otherwise. Her eye examination revealed grade 1 hypertensive retinopathy without any sign of diabetic retinopathy. She also

had bilateral sensorimotor peripheral polyneuropathy. In urine analysis, microscopic hematuria was detected and there were no proteinuria. In doppler ultrasonographic examination, kidney dimensions, renal arteries and bladder wall thickness were normal. 24-hour urine sample was collected and albumin excretion was 25 mg/day and protein excretion was 210 mg/day. ANA and ANCA tests were positive. C3 (1.75 g/dL) and C4 (0.227 g/dL) levels were measured to exclude glomerulonephritis, and were normal. In order to elucidate the cause of renal insufficiency, a kidney biopsy was performed. Pathological examination revealed sclerosis with diffuse mesengial expansion and nodular sclerosis in few glomeruli; findings were suggestive of diabetic nephropathy. She was followed for seven years at three to six-month intervals, and her treatment plan included mixed insulin and an angiotensin converting enzyme inhibitor (ACEi). During her follow-up, her HbA1 c levels were 7 to 8% and eGFRs were 30–40 mL/min. She had been diagnosed with non-proliferative diabetic retinopathy, on the other hand she still did not have microalbuminuria (17.5 mg/day).

Conclusion: Nonalbuminuric renal insufficiency in diabetic patients is increasingly being recognized. Treating diabetic and hypertensive patients with ACEi and angiotensin receptor blockers may contribute to this condition. Nonalbuminuric renal insufficiency may possibly require a revision of diabetic nephropathy classification and this condition may be classified as a new category in the near future.

Keywords: nonalbuminuric renal insufficiency, diabetic nephropathy, chronic kidney disease, microalbuminuria, proteinuria, elderly

PP-34

CHARACTERISTICS OF UPPER AND LOWER GASTROINTESTINAL ENDOSCOPIC FINDINGS IN THE ELDERLY: A SINGLE CENTER STUDY

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Aim: We aimed to define the characteristics and incidences of gastrointestinal (GI) lesions detected in elderly patients who underwent endoscopic evaluation.

Methods: Patients aged 65 and over who underwent upper or lower GI endoscopic evaluation for any indication, such as iron deficiency anemia, dyspepsia, constipation, diarrhea, GI hemorrhage or cancer screening, between 2007 and 2017 were eligible for this study. Medical records of 379 patients with upper GI endoscopy and 241 patients with colonoscopy were retrospectively reviewed. Age, gender, endoscopic findings and histopathological diagnoses were recorded. In case of a GI malignancy, imaging results and surgery notes were also reviewed to determine the stage of the cancer.

Results: Of the 379 patients who underwent upper GI endoscopy, 223 (58.8%) were females, 156 (41.2%) were males, and the median age was 78 (range 65–99). 239 patients (63%) had benign gastric or duodenal pathological findings including chronic non-atrophic gastritis, fundic gland polyp, gluten-sensitive enteropathy, erosion, peptic ulcus, and foveolar hyperplasia. Endoscopic findings were normal in 98 (25.9%) patients. 120 patients (31.7%) had lesions with premalignant potential, including intestinal metaplasia (27.7%), chronic atrophic gastritis (14.8%), and autoimmune gastritis (3.7%). 20 patients (5.3%) had gastric adenocarcinoma. The gastric cancer was stage 1 or 2 in 4 (20%), and stage 3 or 4 in 9 (45%) patients; the stage was unknown in 7 patients. Of the 241 patients who underwent colonoscopy 138 (57.3%) were females and 103 (42.7%) were males, and the median age was 78 (range 65–93). 23 patients (9.5%) had benign lesions including hyperplastic polyps and colitis. 147 patients (61%) had normal colonoscopic findings. Adenomatous polyps were detected in 50 patients (20.7%) and sessile serrated adenomas were detected in 4 patients (1.7%). 17 patients (7.1%) had colorectal cancer. The tumor was located in the left and right colon in 10 and 7 patients, respectively. The colorectal cancer was stage 1 or 2 in 7 (41.2%) and stage 3 or 4 in 6 (35.3%) patients; the stage was unknown in 4 (23.5%) patients.

Conclusion: Data about the results of upper and lower endoscopies in older patients in Turkey is limited. In this descriptive study, we summarized the endoscopic findings of these patients in our center. Premalignant or malignant lesions were detected in 37% of the upper and 29.5% of the lower GI endoscopies, whereas the majority of the patients had benign or normal endoscopic findings.

Keywords: upper gastrointestinal endoscopy, colonoscopy, elderly, premalign gastrointestinal lesions

Table1. Upper gastrointestinal endoscopy results

	n	*%* *
Total	379	100
Gender		
Female	223	58.8
Male	156	41.2
Age-years, median (range)	78 (65–99)	
Benign lesions		
Foveolar hyperplasia	135	35.6
Chronic non-atrophic gastritis	64	16.9
Peptic ulcus	23	6.1
Fundic polyp	14	3.7
Erosion	12	3.2
Gluten-sensitive enteropathy	6	16
Normal mucosa	98	25.9
Premalignant lesions		
Intestinal metaplasia	105	27.7
Chronic atrophic gastritis	56	14.8
Autoimmun gastritis	14	3.7
Gastric adenocarcinoma	20	5.3

*Patients may have more than one pathological diagnosis.

Table 2. Lower gastrointestinal endoscopy results

	n	*%* *
Total	241	100
Gender		
Female	138	57.3
Male	103	42.7
Age-years, median (range)	78 (65–93)	
Benign lesions		
Colitis	10	4.1
Hyperplastic polyp	5	2.1
Other	8	3.3
Normal mucosa	147	61
Premalignant lesions		
Adenomatous polyp	50	20.7
Sessile serrated adenoma	4	1.7
Colorectal adenocarcinoma	17	7.1

* Patients may have more than one pathological diagnosis.

PP-35

THE ALARM BELLS RINGING: A CASE OF LUNG CANCER PRESENTING WITH GOUT.

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Gulhane Research And Training Hospital/Department Of Internal Medicine

Introduction: Gout is a common inflammatory disease characterized by acute arthritis and hyperuricemia. It is caused by monosodium urate crystal deposition in tissues leading to arthritis, soft tissue masses, kidney stones, and urate nephropathy. A number of epidemiological studies have revealed the critical role of gout in carcinogenesis. Gout patients were at an increased risk of cancer, particularly urological cancers, digestive system cancers, and lung cancer.

Case Presentation: A 73-year-old male patient with a 40-year history of gout admitted to the hospital for complaints of swelling, redness and pain in his right foot for one week. Physical examination showed less expansion and decreased respiratory sounds at the basal level of the right lung in addition to increased temperature, redness and edema at the right ankle. Laboratory studies have shown an increase in erythrocyte sedimentation rate, CRP and lactate dehydrogenase levels. The patient was evaluated as acute gout arthritis so colchicine and naproxen sodium were started promptly. With the treatment, signs and symptoms improved rapidly. Irregularity in right pulmonary hilus was observed on the chest X-ray, one of the simplest tests, done with the aim of detecting possible malignancy. As to the knowledge in the literature that gout arthritis may be associated with cancer. The age of the patient, elevated erythrocyte sedimentation rate, and CRP supported this thought. After the HRCT had revealed mass in right lower segment, biopsies taken via fiber optic bronchoscopy were reported as squamous cell carcinoma by pathology. The patient was referred to medical oncology, radiation oncology, and chest surgery for evaluation in terms of radiotherapy, chemotherapy or surgery.

Conclusion: Clinicians should keep in mind that gout disease may be the predictor of malignancies. We found it worthwhile to share our cause with the aim of emphasizing the importance of chest X-ray in diagnosing diseases where early recognition is lifesaving such as lung cancer.

Keywords: Gout, Lung Cancer, acute arthritis

PP-36

DISASTER WITH A SMALL TOUCH: A DRESS CASE DUE TO ANTIBIOTICS

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DRESS (drug reaction with eosinophilia and systemic symptoms) is a drug-related hypersensitivity reaction that is rare but lethal when it is observed. The annual incidence is about 1/100000. Although anti-epileptic agents are the most accused agents, it is thought that the use of any drug may cause the reaction. It is a complex clinical condition including skin findings that begins as a morbilliform rash, spreads all over the body in a short time-mostly accompanied by facial edema-hematological and liver function abnormalities mostly with systemic symptoms such as fever, malaise, lymphadenopathy. We find it worthwhile to share our case as a dramatically terminated example of inappropriate use of antibiotics.

Case Presentation: An 84-year-old female patient with history of atrial fibrillation, congestive heart failure and hypertension admitted to our hospital with diffuse rash in the body and aphtae in the mouth. The patient was reported to have been using multiple antibiotics (amoxicillin, moxifloxacin and ceftriaxone) for the past 10 days due to upper respiratory tract infection. Physical examination revealed fever, cardiac dysrhythmia, poor oral hygiene and bullous lesions in the lower lip and oral mucosa. Erythematous macular morbilliform eruptions widespread over the trunk and purpural rash with a tendency to regress in all limbs were observed. In the laboratory; Eosinophil-predominant leukocytosis, , urea-creatinine, and elevated erythrocyte sedimentation rate, CRP, transaminase levels and accompanying kidney dysfunction were detected. Blood and urine culture for possible infective agents resulted in a negatively. No abnormalities were observed in serological examinations for liver pathologies and rheumatic diseases. 20% of eosinophils were detected in peripheral blood smear. DRESS was diagnosed In light of clinical condition and laboratory changes with presence of a temporal relationship between the onset of symptoms and the drug story. Despite appropriate treatment and support all efforts, the disease progressed rapidly then the patient was transferred, with the diagnosis of toxic epidermal necrolysis, to the intensive care unit where she was lost.

Conclusion: We report this case to emphasize the significance of a detailed drug history whenever a patient presents with pyrexia of unknown origin and systemic complications, with or without a rash. Also a long latent period between the onset of drug intake and the appearance of symptoms (1-week to 3 months) is another point that should be highlighted. Once diagnosed, DRESS can be managed by withdrawing the drug and administering steroids, but mere withdrawal of the drug will not arrest the disease process and a delay in starting steroid treatment may prove fatal as noted in our case

Keywords: DRESS, drug-related rash, antibiotics

PP-37

A CASE OF TUBERCULOUS LYMPHADENITIS AFTER INTRAVESICAL BCG

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Introduction: Intravesical bacillus Calmette-Guerin (BCG), a live attenuated strain of Mycobacterium bovis, therapy, is a highly effective and often preferred treatment for non-muscle invasive bladder carcinoma. It is usually well tolerated, while local side effects can be observed such as cystitis, prostatitis, epididymitis and ureteral obstruction. However, , it should be kept in mind that BCG may also cause systemic and even more serious complications such as hepatitis, sepsis, pneumonia or osteomyelitis. Therefore, we found it worth sharing our patient who developed cervical lymphadenitis after intravesical instillation

Case Presentation: An eighty-year-old male patient with diabetes and chronic renal insufficiency admitted to the hospital with complaints of fatigue. Fever, weight loss and night sweats were declared in systematic interrogation. It was learned that the patient was treated and cured for superficial bladder cancer. No pathology was observed on physical examination. Laboratory tests revealed anemia of chronic disease, impaired renal function, hyperglycemia, hyperuricemia and elevated erythrocyte sedimentation rate. Abdominal ultrasonography and tomography performed in terms of possible malignancy or recurrent bladder carcinoma showed lymph nodes in, the largest in size 21 * 16 mm, the paraortic, paracaval and retrocaval zone. Excisional biopsy performed in the following procedure resulted in caseified granulomatous lymphadenopathy. The patient was diagnosed with lymph node tuberculosis, and isoniazid rifampicin and ethambutol therapy was started. Patient who does not develop side

effects due to treatment, discharged from hospital to be monitored from outpatient clinic.

Conclusion: The current literature is still insufficient in identifying risk factors for detecting patients with a high likelihood of developing complications after BCG. Therefore; in patients who had previously undergone intravesical BCG, clinicians must be awake in signs and symptoms that they cannot explain for other reasons. Isolation of the agent in culture or histopathological examination of the granulomas is very important for diagnosis. It should not be forgotten that the prompt initiation of 3-drug anti tuberculosis treatment is extremely crucial in terms of preventing more serious clinical situations.

Keywords: bacillus Calmette-Guerin (BCG), Mycobacterium bovis, bladder carcinoma

PP-38

VALIDATION OF THE MINI-COG TEST FOR SCREENING COGNITIVE IMPAIRMENT IN TURKISH OLDER ADULTS

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Objectives: Alzheimer's disease is associated with increased morbidity and mortality in geriatric population. There is no gold standard screening test for Alzheimer's Disease. Various screening tools have been developed and among these, the most commonly used one worldwide is the Mini Mental State Examination (MMSE) test. The Mini-Cog test is more brief than MMSE, that consists of assessment of ability to recall three words and draw a clock The objective of this study is to test the validity of the Mini-Cog for identification of dementia in Turkish geriatric patients.

Methods: Three hundred patients aged ≥65 years who were admitted to geriatric medicine outpatient clinic in a university hospital were enrolled between December 2014 and December 2015. Subjects with a history of cerebrovascular event, brain injury, central nervous system infection, excessive use of alcohol and drug abuse, heart or respiratory failure, acute infections, depression, delirium, thyroid problems, vitamin B12 deficiency were excluded as possible confounders of cognitive function. Both MMSE and Mini-Cog test was performed to patients. The concordance between MMSE and Mini-Cog test was analysed by Kappa coefficient. Additionally, two clinicians blinded to MMSE and Mini-Cog results, evaluated the cognitive status of patients. The agreement between the Mini-Cog test results and 'dementia'diagnosis of clinicians according to the Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV, was analysed.

Results: Correlation between the Mini-Cog scores and MMSE scores was strong (rs= 0.814, p<0.001). Kappa agreement between Mini-Cog test and MMSE was at a good level (kappa= 0.79). Sensitivity and specificity of Mini-Cog test were found to be 87% and 95%. A moderate agreement was found between Mini-Cog and clinician's evaluation (kappa coefficients for clinician 1 and 2 were; 0.57 and 0.58 respectively).

Conclusion: The results of the present study suggest that the Turkish version of the Mini-Cog is a valid tool to evaluate cognitive impairment. The Mini-Cog can discriminate cognitively impaired persons to be referred for comprehensive geriatric assessment.

Keywords: Mini-Cog, dementia, screening, validation, cognitive.

Table 1. Characteristics of the study population.

Age (mean±SD)	73.3± 6.2
Gender (n,% male)	171 (57%)
Education status	
Literate but no schooling	134 (44.3%)
Elementary school	68 (22.7%)
Middle school	10 (3.3%)
High school	36 (12%))
College degree	52 (17.3%
Married (n, %)	200 (66.7%)
MMSE (mean±SD)	26.4±5.2
MMSE ≥24 (n,%)	251 (83.7%)
Mini-Cog≥3 (n,%)	245 (81.7%)
Clinical evaluation: Dementia (n,%)	36 (12%)

Table 2: The characteristics of patients with 'possible cognitive impairment' and those who were 'probably normal' according to the Mini-Cog test.

	Mini-Cog<3 n=55	Mini-Cog≥3 n=245	P
Age (mean±SD)	77.3±7	72.4±5.7	0.001
Male Gender (%, n)	47.3% (26)	59.2% (145)	0.1
MMSE (mean±SD)	17.7±6.2	28.4±2	0.001
Education ≤4 years	85.5% (47)	63.7% (156)	0.001
ADL (mean±SD)	4.4±2	5.8±0.7	<0.001
IADL (mean±SD)	17.8±7	23.1±2.8	<0.001

MMSE: Mini Mental State Examination, SD: standard deviation, ADL: Activities of Daily Living, IADL: Instrumental Activities of Daily Living.

PP-39

VARIATIONS IN ANKLE BRACHIAL INDEX MEASUREMENT AMONG TURKISH OLDER AND YOUNGER ADULTS

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Aim: Ankle brachial index (ABI) is a non-invasive diagnostic tool to detect peripheral arterial disease (PAD) which is a more common disease among elderly. Although ABI measurement has high sensitivity and specificity in comparison with the gold standard angiography, variations on different occasions in the same individual is likely. We have previously shown good correlations among three different ABI measurements on different occasions, albeit with significant variations in 12% of individuals. In the present study, we tested whether geriatric subjects display differences with regard to ABI variability compared to younger adults.

Materials and Methods: Men and women with no contraindications for ABI measurement were enrolled prospectively. Enrollees underwent three courses of ABI measurements on different occasions using a handheld Doppler device. Two measurements were obtained in the morning and afternoon, and a third one was recorded at least 7 days apart. Variation was defined as 0.15 or more difference in ABI values between two readings. All measurements were performed by the same observer to prevent inter-observer errors. The same setting was used for all measurements. Intraclass correlation coefficients (ICC) were calculated for variations among the three ABI readings using two-way mixed effects model.

Results: The study included 161 individuals with ABI measured on all three occasions. There were 42 subjects at or above 65 years of age (72.4±4.5) and 119 younger adults (mean age: 44.9±16.8). Mean ABI among the geriatric group was similar to the younger adult group (1.13±0.12 vs. 1.13±0.14, p=0.409). More than 0.15 variations in ABI values on different occasions were found in 9.5% of geriatric individuals, and 17.6% of younger subjects, with no statistical significance. In the geriatric age group, ICC was 0.806 for single and 0.926 for average measurements (the closer the ICC to 1.0, the more reliable the repeat ABI measurements). In the younger age group, ICC was 0.810 for single and 0.927 for average measurements.

Conclusions: ABI measurement was found highly reliable when applied in the same older adult for three times on different occasions, with no difference with younger individuals. This study confirms the validity of a single ABI measurement to detect PAD among geriatric people.

Keywords: ankle brachial index, reliability, reproducibility

PP-40

CIGARETTE INDUCED CHRONIC MESENTERIC ISCHEMIA

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Background: Chronic mesenteric ischemia (CMI) is an unusual and well toletared pathology because there is usually abundant mesenteric collateral circulation, progressive stenosis of one or more major mesenteric vessels (1–2). The disease usually manifests in patients above 60 years of age. It is typically revealed by abdominal pain after consuming food that lasts for 1–4 h. The diagnosis of CMI is sometimes difficult because of nonspecific symptoms (3). Atherosclerosis is the most common etiology of CMI. We want to present a new case of CMI with no etiologic risk factor except smoking.

Case Presentation: 74-year-old woman who had continuous abdominal pain for 2 weeks with vomiting and diarrhea was admitted to our clinic. She had no other symptoms or chronic diseases. Her past medical history showed that she is smoking 58 pacs/year. Her physical examination revealed that diffuse abdominal pain without peritoneal signs. Blood analysis showed Hb 14.9 g/dL, WBC count 25600/mm^3, platelets 394000/mm^3 and CRP 7.49 mg/dL (0–0.8). Also liver function tests, renal function tests and electrolytes were within normal limits, amylase were 90 U/l (25–100). Abdominal ultrasound imagining showed that no pathological sign. Abdominal computerized tomography (CT) revealed that although the celiac and superior mesenteric arteries were occluded at the proximal portion. Contrast enhanced CT revealed that celiac truncus proximal 1 cm segment and inferior mesenteric arterial severe stenosis, superior mesenteric artery proximal 4 cm segment total occlusion and collateral perfusions, common atherosclerotic plaques in 1/3 distal aorta, total occlusion of left common iliac artery, right external iliac artery and collateral perfusions, stenosis in right common iliac artery. She was diagnosed as acute exacerbation of CMI, and we performed celiac stent implantation. She was evaluated for hypertension diabetes mellitus, hyperlipidemia and no other risk factors were diagnosed. After the stent implantation, she was free from abdominal pain and discharged. Conclusions: Atherosclerosis is increasing in prevalence with age and common in geriatric population. Although there are many risk factors for atherosclerosis formation, current cigarette smoking is enough for common atherosclerosis in elderly (4). Smoking cessation in all age groups is important. Also atypical presentations like continuous acute abdominal pain, keep abdominal atherosclerosis diagnosis at the back of our minds. This case shows us that, atypical presentation of illnesses and peripheral athrosclerosis and CMI in the case of low risk factors could seen in elderly. Endovascular stent placement, transluminal angioplasty or surgical revascularization are treatment options of CMI. Symptoms are resolved in% 88 patients after endovascular treatment (5). Also our patients symptoms totally resolved after stent implantation. Due to this reason, treatment options could be performed in elderly patients independently of their comorbidities.

Keywords: Chronic mesenteric ischemia, Cigarette Smoking, Endovascular Treatment

PP-41

HYPERCALCEMIC CRISIS IN SYSTEMIC LUPUS ERYTHEMATOSUS

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Özet: Şiddetli hiperkalsemi genellikle sistemik lupus eritematosus (SLE) olan hastalarda görülemeyen primer hiperparatiroidizm (PHP) nedeniyledir. Bu olgu sunumunda 77 yaşinda SLE öyküsü olan bir kadin hafif hiperkalsemi geliştirmektedir.

Giriş: Hiperkalsemik kriz (HCC), kalsiyum homeostazi bozukluğundan kaynaklanan akut veya kronik hiperkalseminin nadir bir komplikasyondur. Taninmayan primer hiperparatiroidizm (HK), HCC'nin ana nedenidir. Sistemik lupus eritematosus (SLE) 'de hiperkalsemi görülme olasiliği vardir ancak nadiren PHP kaynaklanmaktadir. Bu olgu sunumunda, SLE öyküsü olan 77 yaşinda bir kadin tani konulmamiş PHP'ye sekonder olarak HCC geliştirir ve şiddetli hiperkalseminin akut yönetiminde uzun süreli iyileşme görür.

77 yaşinda kadin hasta bilinç bulanikliği yüzünden hastanemize başvurdu. Bir fizik muayene hepatosplenomegali kaydedildi. The values obtained during the initial laboratory examination (Table 1).

Hiperkalsemi, yaygin bir elektrolit anormalliğidir. Hiperkalsemi vakalarinin% 90'indan fazlasinda primer hiperparatiroidizm, malignite bağlidir. Hiperkalsemi, paratiroidle ilişkili protein (PTHrP), interlökin 1 ve 1.25 (OH) 2-vitamin D3 dahil olmak üzere lokal kemik yikimi ve/veya humoral faktörlerden kaynaklanir. Genel olarak tümoral hiperkalsemide azalir. Literatürde, SLE'nin hiperkalsemi belirtisi olan birkaç olgu vardir. Olgularin hepsinde, SLE'nin remisyonda olmadiği zaman hiperkalsemi saptanmiştir. SLE'de hiperkalseminin etyolojisi açik değildir. Bazi vakalarda, PTHrP üretimine atfedilir ve bazi durumlarda PTH benzeri otoantikorlari uyarmak etkilenir. PTH otoantikorlarinin B lenfositlerinin poliklonal aktivasyonuna ikincil olarak gelişebileceği hipotezi ileri sürülmüştür. Ayrica proinflamatuvar sitokinler aktif SLE fazlari boyunca yükselir ve doğrudan kemik döngüsünü artirabilir ve hiperkalsemiye yol açabilir.

PHP tipik olarak erişkin bir hastalik olarak kabul edilir ve PTH saliminin kalsiyum seviyelerinden bağimsiz olduğu veya PTH saliniminin kalsiyumun indüklediği baskilamanin yükseltildiği zaman hiperkalseminin ortak bir nedeni olarak ortaya çikar. PHP'li hastalarin yaklaşik% 80–85'i benign paratiroid adenomlarina sahiptir. Genellikle cerrahi tedavi ile tedavi edilmektedir. Olgumuz parathyroidektomi, hastanin ölümesi nedeniyle başarisiz oldu.

Gerçekten de, lupus tanisi, hiperkalsemi oluşmadan önce tespit edilemeyebilir. Bu nedenle, klinik ve immünolojik ipuçlari, bilinmeyen kaynakli hiperkalsemi bulunan bir hastada SLE tanisini önermektedir. Çünkü hiperkalsemi lupus aktivitesiyle ilişkili gibi görünüyor. Sonuç olarak, lupus hiperkalsemik kriz vakalarinda akla gelebilecek hastaliklardan biridir.

Keywords: primary hyperparathyroidism; hypercalcemic crisis; systemic lupus erythematosus

Tables:

Table 1. Labaratory data						
	CA (mg/dl)	PTH (pq/ml)	HB (g/dl)	WBC (10^3/Ul)	Ne (10^3/Ul)	PLT (10^3/Ul
1 week	15.7	1046.5	8.2	3089	1028	191.000
5 week	13.6	872.8	7.7	2900	600	190.000

PP-42

A RARE WALDENSTRÖM'S MACROGLOBULINEMIA CASE WITH SUBCUTANEOUS BULKY MASSES

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Waldenström's macroglobulinemia (WM) is a hematological malignancy characterized by the presence of lymphoplasmacytic bone marrow infiltration and monoclonal immunoglobulin M (IgM).

We herein describe a case with WM who presented with extensive subcutaneous lesions as bulky masses without any organ/bone marrow involvement.

Case: A 71 year-old female patient who had hypertension, type-II diabetes mellitus and hypercholesterolemia known for the past 15 years presented with asthenia, loss of appetite and weight loss (22 kgs in 2 months) h. In the physical examination she had large, subcutaneous masses in her right distal femur, sacral region, back, abdomen and scalp (Fig. 1). There was no peripheral lymphadenopathy and organomegaly. Hemodialysis was performed due to her hypercalcemia. The funduscopic examination performed due to the hyperviscosity pointed to edema and the hyperviscosity measurement was slightly beyond the limits hereas the patient showed no symptom in terms of hyperviscosity [initial 5.46 cp (3.5±0.5), after two dialysis 3.06 cp. Clonal IgM kappa was detected in serum immunoelectrophoresis with no increase in kappa and lambda light chains in 24-hour urinary test. Cryoglobulin and cold agglutinins were positive while direct and indirect coombs were negative. There was nothing characteristic in her examination of the flow sent from peripheral blood. A bone marrow biopsy could not be performed due to the presence of huge masses with an increased vascularity detected by ultrasound over the posterior iliac regions. So, a sternal bone marrow aspiration was done which revealed no increase in the percentage of plasma cells (1%). PET FDG (19.04.2016) scans showed multiple gross mass lesions coexisted with extensive hypermetabolism in subcutaneous planes and enhanced FDG involvements in malignancy level of these lesions (Fig. 2A). An excisional biopsy was performed which was consistent with plasmacytoid lymphocytic lymphoma. Congo red was negative. Serum urea, creatinine, and calcium levels returned to normal and she did not require further hemodialysis after intravenous dexamethasone with hydration. She received 6 courses of chemoimmunotherapy (cyclophosphamide, doxorubicin, vincristine and prednisone; R-CHOP) with achieving complete metabolic and anatomic remissions in PET-CT (28.09.2016) (Fig. 2B)

Discussion: In our case, multiple hard fixed masses in the subcutaneous tissue in her hairy scalp, back, gluteal region, leg, breast and abdomen were observed during examination. PET FDG scans showed extensive, major and solid lesions that suggested elevated hypermetabolism while no internal organ involvement was detected for the patient. After R-CHOP therapy a significant decrease was detected in the patient's masses after the 6th cure and the lesions in her abdomen became too small to characterize at CT. The patient's follow-up through the hematological polyclinics is still in progress.

Keywords: Waldenström's macroglobulinemia, subcutaneous bulky masses,

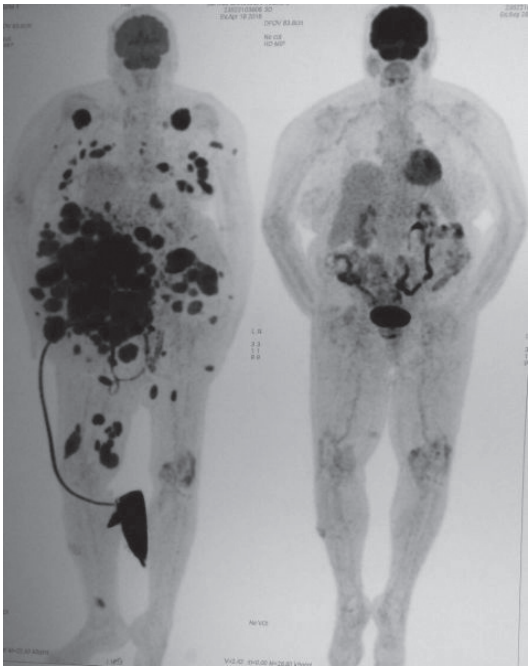

Figure 1.

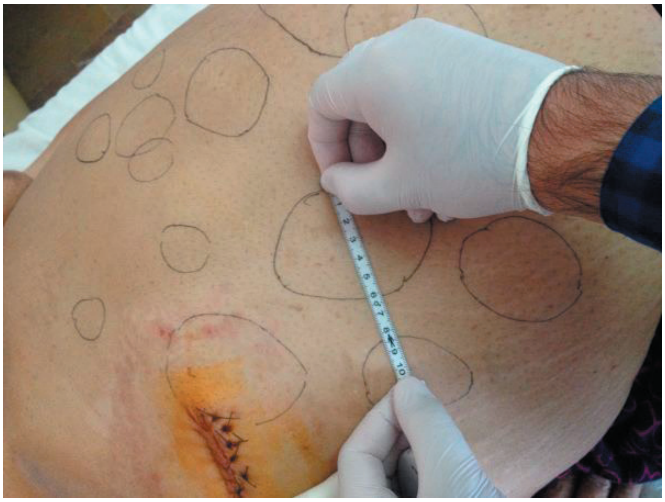

Figure 2.

Table 1. Initial Laboratory Results			
WBC	6800	IgM	4428 mg/dl
Hgb	12.4 gr/dl	IgA	160.2 mg/dl
Htc	% 32.9	IgG	922 mg/dl
Plt	281.000	Beta-2-microglobulin	12750 ng/ml
Urea	81 mg/dl	Reticulocyte	% 1.92
Creatinine	2.7 mg/dl	Haptoglobulin	186 mg/dl
Na	128 mmol/L	Serum Hiperviscosity	5.46 CP
K	5.7 mmol/	CRP	27.7 mgr/L
Ca	17.3 mg/dl	Sedimentation	102 mm/hr
P	2.2 mg/dl	LDH	377 IU/L
Uric acid	10.7 mg/dl	PTH	14.9 pg/ml
Albumin/Globulin	3.3/7.3 gr/dl	25-OH-D vit	16.5 µg/L
AST/ALT	44/15 IU/L	ALP/GGT	36/17 U/L
D. Bil/I. Bil.	0.21/0.34 mg/dl		

PP-43

COMPARISON OF DIAGNOSTIC TESTS AND IMAGING METHODS USED IN ALZHEIMER'S DISEASE

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Objective: The aim of this study is to evaluate the possible relation and correlation between comprehensive geriatric assessment tests, metabolic function of brain determined by positron emission tomography (PET CT) and volumetric analysis measured by magnetic resonance imaging (MRI) in patients with Alzheimer's Disease (AD).

Method: Thirty seven (37) patients who had diagnosis of AD were included. In addition to baseline characteristics, comprehensive geriatric assessment tests, metabolic measurements in 8 different localization by using PET CT in all patients and volumetric analysis in 14 different regions by using cranial MRI in 16 patients were performed.

Results: Moderate to severe hypometabolic activity was most frequently observed in left temporal lobe (43.2%). Thereafter, right temporal lobe (37.8%) and right and left parietal lobes (32.4%) followed left temporal lobe. Besides, normal metabolic activity was most frequently seen in right frontal lobe (75.7%). In 16 patients, mean±SD right, left and total hippocampal volumes were 3128±732, 3088±791 and 6217±1459 mm3 respectively. Montreal Cognitive Assessment (MOCA) was found to be significantly lower in patients with moderate to severe hypometabolism in left temporal, right and left parietal lobes than that of mild hypometabolic and normometabolic patients (p=0.033, p=0.032 and p=0.028). In patients with moderate to severe right parietal hypometabolism, forward digit span test was lower (p=0.031) and geriatric depression scale was higher (p=0.023). There was no relationship between precuneal and frontal hypometbolism and comprehensive geriatric assessment tests. In correlation analysis, there were negative correlations between right temporal hypometabolism and forward digit span test (r=-0.304 p=0.047), mini mental state examination test (MMSE) (r=-0.301 p=0.048) and MOCA (r=-0.296 p=0.050); between left temporal hypometabolism and forward digit span test (r=-0.324 p=0.050), MMSE (r=-0.394 p=0.016) and MOCA (r=-0.353 p=0.032); between right parietal hypometabolism and forward digit span test (r=-0.427 p=0.008), MMSE (r=-0.324 p=0.050) and MOCA (r=-0.433 p=0.007); left parietal hypometabolism and forward digit span test (r=-0.377 p=0.021), MMSE (r=-0.325 p=0.047) and MOCA (r=-0.439 p=0.007) and between both right and left precuneal hypometabolism and MMSE (r=-0.356 p=0.031 and r=-0.332 p=0.044). There were negative correlations between left temporal hypometabolism and left (r=-0.420 p=0.005) and total hippocampal (r=-0.254 p=0.017); between right precuneal hypometabolism and total (r=-0.410 p=0.005) and right parahippocampal (r=-0.435 p=0.007) and between left precuneal hypometabolism and total (r=-0.406 p=0.008) and right parahippocampal (r=-0.439 p=0.007) volume.

Conclusion: This study showed relationship between 14 different geriatric assessment tests, hypometabolic activity of 8 different anatomic localizations and volumetric analysis of 14 different brain regions.

Keywords: Alzheimer's disease, neuropsychiatric inventory, cranial volumetric analysis

PP-44

PATIENT PERCEPTION OF STANDING DORSOGLUTEAL INTRAMUSCULER INJECTION IN GERIATRIC POPULATION

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Introduction: Intramusculer injection (IM) is one of the most performed invasive procedures for the geriatric patients which is generally performed at the primary health-care facilities. It may be done while the patient is lying or standing. Although the lying position is the most common choice for application, it is generally more difficult and time consuming for the geriatric population because of the mobility issues. The aim of this study was to assess the patient perception of standing dorso-gluteal (DG) IM injections in geriatric population.

Materials and Methods: Geriatric patients who had admitted to a primary health-care facility for IM injection between June-July 2016 were chosen for the study. In order to standardize the procedure, only the patients who had received B12 vit. injections were included. These patients were prescribed to receive these injections each day for one week. First day, the IM injections were done while the patients were lying and second day while standing. Standart DG injection technique and protocol was used for all patients. All injections were done by the same RN (author). Patients were asked to rate the level of comfort of the injection by marking on a 10-point VAS-scale for each injection position. Statistical analysis were performed by SPSS for Windows.

Findings: Twenty-nine patients (16 female, 13 male) aged between 48–90 (71.10± 2.02) were studied. The mean VAS-scale score was 9.79 for standing position and 5.93 for lying position. This difference was statistically significant ($p < 0.001$).

Results: In this study, standing DG-IM injection is reported to be more comfortable in geriatric patients. Therefore, standing position may be advised for DG-IM injection for this group of patients.

Keywords: Intramusculer injection, geriatric, quality of life

PP-45

PROPHYLTHIOURACIL A RARE CAUSE OF ERYTHEMA NODOSUM: A CASE REPORT

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Aim&Background: Erythema nodosum is a type of pannucilitis effecting subcutaneous fatty tissue (1). Although it is mostly idiopathic, it may be due to vasculitic syndromes (Behçet's disease, Takayasu arteritis), infectious diseases (mostly streptococcal infections), sarcoidosis, enteropathies, drugs, and paraneoplastic syndromes (1, 2). Treatment depends on etiology after making the diagnosis with systemic evaluation of the patient. In this case we make the diagnosis of erythema nodosum on a patient with a history of usage of prophylthiourasil.

Case Report: Sixty six years old female patient admitted to our clinic with the complaint of swelling on her legs for 3 years. On her past medical history, there is hypertension for 15 years, diabetes mellitus for 10 years and hyperthyroidism for 3 years. Due to these diseases she was on nifedipine and metformin medications. No history of smoking and alcohol was present. We have performed a biopsy to lesions on her legs. Histopathologic examination revealed us the diagnosis of erythema nodosum. She was evaluated for accompanying diseases. There were no oral lesions, ulcers on genitelia or uveitis. Chest X-Ray, ACE level, ANCA, ANA, Anti ds DNA levels were within normal limits. Screening for malignancy and inflammatory diseases were negative. Because of history of taking prophylthiouracil, we stopped this medication and lessions resolved spontaneously at her follow up.

Discussion: Prophylthiouracil is an antithyroidal drug and may cause fever, leukopenia, artritis, vasculitis, lupus like syndrome, interstitial pneumonia, and erythema nodosum in very few patients. Clinicians must review all of the drugs used by the patients who have erythema nodosum.

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Keywords: erythema nodosum, prophythiouracil, adverse event

PP-46

HEPATIC PORTAL VENOUS GAS AND PNEUMATOSIS INTESTINALIS

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Introduction: Hepatic portal venous gas is rare, and its mechanism is not fully understood. It may develop as a result of various conditions. Pneumatosis intestinalis (PI) is a rare condition characterized by multiple gas-filled submucosal or subserosal cysts in the small and/or large intestine walls. PI is a radiological sign and is often associated with HPVG. It occurs when translocation of luminal gas to the intestinal mucosa creates small air pockets in the bowel wall.

PI is divided into 3 types: primary, secondary, and infantile. In the primary or idiopathic type, there is no underlying cause or predisposing factor. With secondary PI, there is a predisposing pathological condition and underlying cause such as intestinal obstruction, ischemia, or infection.

In this report, we describe the case of a 61-year-old patient who presented with nonspecific clinical symptoms and was found to have HPVG and PI. We also reviewed the literature and examined the diagnostic and treatment approaches to this rare condition.

Case: A 61-year-old female patient presented to the emergency department with complaints of abdominal pain. On physical examination she had distention and defense on abdominal examination. Her medical history included chronic kidney failure, hypertension, diabetes mellitus, coronary artery disease, and cardiac arrhythmia; she had undergone surgery 8 months earlier for mesentery venoocclusion.

Laboratory tests results were as follows: white blood cells: 18.70 $x10^3/\mu L$, C-reactive protein: 0.8 mg/dl, creatinine: 6.5 mg/dl, alanine aminotransferase: 32 U/L, aspartate aminotransferase: 44 U/L, alkaline phosphatase: 142 U/L, amylase: 148 U/L. Ultrasonography to identify etiology of acute abdomen could not be performed due to gas. Abdominal tomography revealed density consistent with gas in the portal vein, liver, and splenic vein, and the appearance of distention and dilation consistent with gas was noted in the intestines, particularly the small intestine. The diameter of the intestines was enlarged up to 6 cm.

She was taken for emergency surgery for acute abdomen. Upon exploration, widespread edema of the entire small intestine after the Treitz arch, ischemia of the jejunal segment about 30 cm distal of the Treitz arch were observed. There were gas-filled cysts ranging in size from 0.2–0.5 cm in diameter in the small intestine serosa. A pulse was present in the superior mesenteric artery and inferior mesenteric artery. Gas was aspirated through a puncture in the superior mesenteric vein. The ischemic bowel section was resected and a tip ileostomy was performed. Reexploration was planned and the operation was concluded. The patient died 8 hours postoperatively due to sepsis.

Conclusion: HPVG is a condition requiring emergency intervention and is associated with high mortality. As in our case, PI and HPVG occur together 70–80% of the time and such cases have higher mortality compared to patients with HPVG alone.

Keywords: pneumatosis intestinalis, hepatic portal venous gas

PP-47

AN ELDERLY PATIENT ADMITS TO EMERGENCY DEPARTMENT WITH CONCIOUSNESS PROBLEMS AND.

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Introduction: Evaluation of an elderly patient may be difficult because of physiologic changes and comorbidities in this age group. In addition, the incidence of some disease is increasing with age. The frequency of atypical presentations is higher in elderly patients with emergency service or outpatient clinics than in younger patients.

Case: 93 years old female patient was admitted to emergency department with consciousness changes, hallucinations, unable to eating and deterioration in general case. Her family told that she could

do daily activities until yesterday. But she felt fatigue at first, then hallucinations started, stopped to eating and started to sleeping continously. In her story there was by-pass operation, hypertension and insulin resistance. She was using metoprolol, metformin, warfarin and aldactaside. When she admitted to emergency department general situation was bad, cooperation and orientation were limited. Blood pressure was 137/82 mmHg, heart rate was 92/rhytmic, temperature was 37.1 degrees celcius. There were crepitant rales in both of basal areas and left middle lung lobes. In neurologic examination there was no lateralisation, there was response to verbal comments but effective neurologic examination couldn'b be done. Leukocytes: 4.88, neutrophil: 76% lymphocyte 16%, monocytes 7.8%, Red Blood Cells: 2.99, Hemoglobine: 11.[1] Hematocrite: 34.4% MCV: 115.1 fL, MCH: 37.1, Platelet: 86, CRP: 31 (Normal value<5), ALT, AST, GGT, BUN, kreatinin, electrolytes, lactate, troponin I, CK, CK-MB were in normal ranges. In cranial magnetic resonance imaging (MRI) there was diffuse chronic gliotic changes, cerebral and cerebellar atrophy, beside that, mild diffusion restriction was seen in mesenchephalon and brain stem, in the middle cerebellar pedincules and bilateral posterior area. Subacute infarct was questioned by radiology specialist. The patient was consulted with neurology and infectious disease specialists. After all clinic, laboratory and imaging results'evaluation it was decided that the cause which bring the patient to the hospital is not a neurologic problem, this elderly patient had pneumonia and at the same time there were some imaging findings because of megaloblastic anemia. Than chest X-ray was taken and pneumonia was seen.

Discussion: An elderly patient has challenging manifestations for clinician. In our patient, story, symptoms and MRI findings suggested a neurologic problem but it must be known that there are a lot of reason to mimic neurologic problems in an elder person. In laboratory, megaloblastic anemia was noticed. In geriatric people leukocytes may be normal in a serious infection. Neuroanemic syndrome is a disorder occuring as a result of vitamin B12 deficiency and occurs frequently among elderly people, but it is often unrecognized; it can cause neuropsychiatric problems. It must be kept in mind that in an elder person, a new starting infection can cause rapid worsening and both of infection and neuroanemic syndrome can mimic neurologic disorders.

Keywords: neuroanemic syndrome, elderly, infection, pneumonia, consciousness, somnolance

PP-48

A GERIATRIC CASE OF CONNECTIVE TISSUE DISEASE PRESENTING WITH SEVERE FATIGUE AND PERIPHERAL NEUROPATHY

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Introduction: Connective tissue diseases (CTD) can present with a wide spectrum of neurological symptoms effecting both central and peripheral nervous system (PNS). Chronic idiopathic demyelinating polyneuropathy (CIDP) is unusual in CTD. We describe herein, 80-year-old patient with CTD who exhibited CIDP and cranial nerve paralysis.

Case: A 80-year-old woman patient presented with 4 months history of diffuse myalgia, numbness and loss of weight. The medical history of the patient included only mild type 2 DM. Until the onset of the symptoms, she reported that she could perform all of her daily activities independently. In this duration, she had also lost 4–5 kg. Physical examination revealed whole of her body was tender by palpation. Laboratory tests showed mild anemia, lymphopenia, elevated acute phase reactants and mildly elevated liver enzymes. Polymyalgia rheumatica and CTD were considered as prediagnosis, autoimmune screening panel was requested and methylprednisolone (16 mg/day) was administered. Malignancy was also suspected and PET CT was planned. PET-CT was negative for any malignancy and myositis was reported in the foreground. ANA was positive at a dilution of 1/100, anti Ro (++), anti Ro-52 (+). Salivary gland biopsy was performed, it was reported as nondiagnostic. Pregabalin, hydroxychloroquine, methylprednisolone were prescribed. With this treatment the patient reported that her pain relieved but in the following months she reported paresthesia was worsened and balance problems occured. In EMG examination "a mixed type sensorymotor polyneuropathy" was determined. CIDP was considered and intravenous immunglobulin was started.

On the 6th month of follow up patient admitted to hospital with diplopia. Ptosis of the right eyelid, nervus abducens paralysis, mildly reduced strength of proximal extremity muscles were detected. Sedimentation rate was 82 mm/h and no pathological findings were detected in cranial MR. CSF protein was found mildly elevate and oligoclonal band was positive (pattern 3) on cerebrospinal fluid (CSF) sample analysis. This problem was considered secondary to CTD and high dosage pulse steroid treatment was administered first and then maintenance therapy with prednisolone was continued and azathioprine was added. During hospitalization acute thrombus in left popliteal was detected. No sign for pulmonary embolism was found, enoxaparin was started and maintenance therapy was planned with warfarin. However no improvement was observed in cranial nerve paralysis. On her follow up, chronic venous ulser on left leg developed, and sepsis secondary to wound site infection lead her death.

Conclusion: Connective tissue diseases are usually seen in reproductive age and rare after 65 years of age. In our case, an infrequent neurological disorder, CIDP, was observed secondary to late onset CTD. In geriatric patients with unknown etiology and constitutional symptoms accompanying neurological findings, CTD should also be considered.

Keywords: Geriatric, connective tissue disease, chronic inflammatory demyelinating polyneuropathy, neuropathy

PP-49

WHAT IS THE REASON OF THE MEDIASTINAL ENLARGEMENT IN THIS CHEST X-RAY?

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Introduction: Differential diagnosis of a wide mediastinum consists of the pathology related with the mediastinal organs such as heart, vessels, esophagus, hilar structures of the lung etc. One of the rare reasons for the enlargement of mediastinum is tortuosity of descending aorta with usually asymptomatic presentation. In this case, we present an elderly patient with dyspepsia resistant to medical management and detected tortuous aorta in the chest imaging.

Case Presentation: An 84 year old female with a medical history of coronary heart disease, hypertension, atrial fibrillation and asthma admitted to our geriatric department. She had progressive dyspnea with reduced exercise tolerance and a prolonged history of investigated dyspepsia aggravated over the last six months. Because of the abnormal opacity in the right para-cardiac area on chest x-ray (Figure) the patient underwent computerized tomography scan of thorax. CT scan revealed dilated ascending aorta and trachea deviated to right

side secondary to distinctly curved course of descending thoracic aorta without any other pathologies. Prolonged dyspeptic complaints of the patient were thought to be related to anatomic malposition of aorta. The patient was decided medical follow-up without any surgical procedure for tortuous aorta in the direction of the cardiothoracic surgeon.

Discussion: Tortuous aorta is rarely seen aortic malposition and generally found in asymptomatic elderly patients. Although its etiology is not well described in the literature, hypertension and obesity are thought to be the underlying factors causing this condition. Some of the case reports presented in the literature has shown that it may cause dyspeptic complaints because of its compression to esophagus. Because of the underlying co-morbidities and advanced age of the patients, surgical treatment of tortuous aorta is rarely applied unless accompanied by large aneurysm.

Keywords: Tortuos, aorta, mediasten, dyspepsia

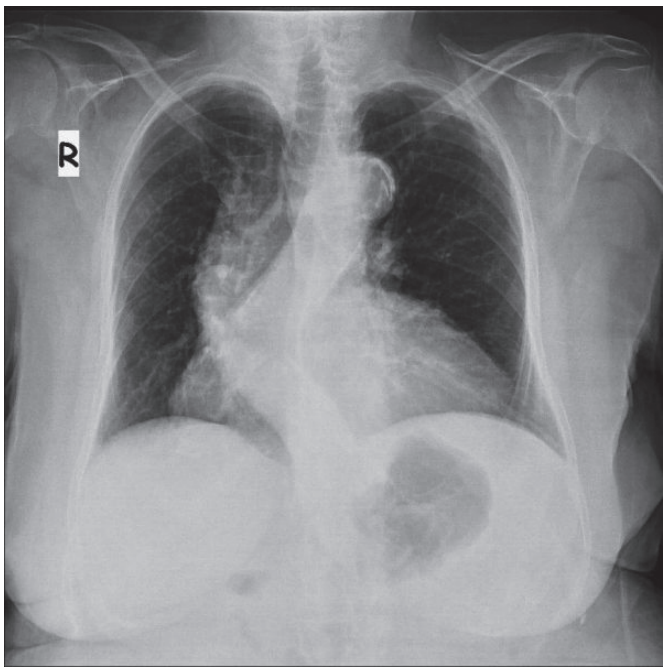

Figure 1.

PP-50

A RARE CAUSE OF DYSPHAGIA IN AN OLDER ADULT: FORESTIER'S SYNDROME

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Introduction: Forestier's syndrome (diffuse idiopathic skeletal hyperostosis) (DISH) is rarely seen and characterized by ossification of the anterolateral aspect of at least four contiguous vertebral bodies. The exact etiology is unclear. The most common symptoms in Forestier's syndrome are pain and movement restriction in the affected spinal cord region. Incidence of dysphagia in patients with Forestier's syndrome with neck involvement is 28%. In this report, we presented a geriatric case with Forestier's syndrome causing dysphagia and weight loss.

Case presentation: An 86 years old male patient admitted to our outpatient clinic with decreased oral nutritional intake and weight loss more than five pounds for last six months. He had hypertension, congestive heart failure and coronary artery disease. He described swallowing difficulty more pronounced with solid foods for the last one month. Patient was hospitalized for further evaluation of dysphagia. To rule out esophageal malignancy or diverticulosis, barium esophagography and esophagogastroscopy were performed. It was seen in endoscopic evaluation that there was an angulation in post-cricoidal region of esophagus that was causing difficulty to pass endoscope. Barium esophagography revealed an obstruction due to DISH of the cervical vertebra that suppressed the esophagus from posterior (Figure 1). Lateral cervical x-ray imaging demonstrated the Frostier's syndrome (Figure 2). The patient was diagnosed as dysphagia related DISH of cervical vertebras. The operation cannot be performed due to advanced age and multiple comorbidities. Oral nutritional supports with thickened up supplements were recommended to maintain adequate nutrition and calorie intake.

Conclusion: Dysphagia only with the solid foods is usually considered as a sign of malignancy of esophagus in advanced age. The rare conditions causing dysphagia such as DISH should also be kept in mind in clinicians evaluating older patients that presented together with dysphagia and movement limitation of the neck.

Keywords: Dysphagia, Forestier's Syndrome

PP-51

A RARE CAUSE OF SEVERE KNEE PAIN IN A GERIATRIC PATIENT: LYMPHOMA PRESENTED WITH TIBIAL MASS

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Introduction: The common causes of knee pain in older adults are osteoarthritis, crystal arthropathies or septic arthritis. Malignancies are rarely diagnosed in elderly patients with knee pain. In this report, a geriatric female patient presented with severe knee pain due to lymphoma complicated with osteomyelitis will be reported.

Case presentation: A 71 year-old female patient was initially admitted to the orthopedics and traumatology outpatient clinic with complaints of severe left knee pain unresponsive to oral analgesic drugs for two months. Severe knee osteoarthritis, anemia, increased erythrocyte sedimentation rate and C-reactive protein levels were detected in her initial evaluation by orthopedic clinician. Before planning operation for knee osteoarthritis, she was consulted to geriatric outpatient clinic for the preoperative evaluation of elevated inflammatory markers and anemia. Patient was admitted to our geriatric clinic for further evaluation. In her physical examination; she had warmth and tenderness on her left knee and tibia. X-ray was consistent with knee osteoarthritis and degenerative findings. Joint aspiration was performed to rule out septic arthritis and non-inflammatory pattern and had no bacterial growth in culture. Magnetic resonance imaging of the knee revealed marked diffuse medullary pathological signal changes in approximately 6.5 cm length of the segment of the proximal third of the left tibia extending to the tibial plateau. The lesion was associated with loss of cortical integrity of the anterior and posterior segments of tibia and also there was soft tissue component showing the extention to neighboring tissues obliterating the popliteal fossa with close proximity of the neurovascular bundle. In order to search for possible concomitant osteomyelitis, leukocyte marked scintigraphy was performed which suggested concomitant osteomy-

elitis of tibia. Ampicillin and sulbactam anti-biotherapies were given to treat osteomyelitis for six weeks. In addition, tru-cut biopsy from the lesion on the proximal tibia was taken which revealed diffuse large B-cell lymphoma. Bone marrow biopsy and Positron Emission Tomography-CT were performed for staging. Pathologically elevated 18F-Flouro-Deoxy-Glucose uptake in the parts of the right lobe of the thyroid gland, in the left axillary lymph nodes, in the right humerus and in both tibias were observed. Bone marrow biopsy was normocellular. Based on these findings, the stage of lymphoma was considered as IVE. The patient was referred to hematology department where systemic chemotherapy and radiotherapy were started for further treatment.

Discussion: In the elderly patients, differential diagnosis of knee pain complicated with increased warmth over the knees and elevated inflammatory markers usually consists of septic arthritis, osteomyelitis and crystal arthropathies, but a rare cause of knee pain such as malignancies including lymphomas should also be kept in mind.

Keywords: lymphoma, knee pain, tibial mass

PP-52

ASSOCIATIONS OF PHYSICAL PERFORMANCE, MUSCLE STRENGTH AND GERIATRIC SYNDROMES BY GENDER IN AN OUTPATIENT CLINIC

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Objective: Elderly patients are complex and they suffer from comorbid diseases and geriatric syndromes. In this study, we aimed to present characteristics of geriatric patients applied to the outpatient clinic recently and to investigate the associations of physical performance, muscle strength and geriatric syndromes and activities of daily living according to gender. Material Methods: Patients with ≥65 years of age consulted in the outpatient clinic of geriatrics section of the internal medicine department recently were included in the study. Mean age, body mass index (BMI), fat free mass (FFM), fat mass (FM), mini nutritional assessment-short form (MNA-SF) score, 4-m gait speed, hand grip strength, activities of daily living (ADL), instrumental ADL (IADL), mini-mental state examination (MMSE), medications, and comorbid diseases were recorded. Results: A total of 114 patients ≥65 years of age consulted in the outpatient clinic of geriatrics section of the internal medicine department recently were included in the study. Data of the patients are shown in Table 1. Illiterate women (26%) were higher than men (8.6%), (P = 0.04). There was no difference between men and women pertaining to physical activity, mobility, and living situation. Conclusions: Present geriatric syndromes, physical performance of the patients and relationships between the parameters will be discussed according to gender.

Keywords: physical performance, muscle strength, geriatric syndromes, gender

Table 1. Characteristics of the patients (n =114)

Age (years)	77 ± 7.7 (65–97)
Women, n (%)	77 (68.8)
Illiterate, n (%)	23 (20.5)
Living alone, n (%)	7 (6.3)
Frequent physical activity, n (%)	8 (7.1)
Chronic diseases, n (%)	3.5 ± 1.8 (0–8)
Medication number n (%)	6.3 ± 3.6 (0–16)
BMI (kg/m2)	31.16 ± 6.3 (19–44)
MNA-SF score	9.3 ± 3.5 (0–14)
MNA score	21.1 ± 6.3 (4–29)
FFM (kg)	47.2 ± 8.3 (38–60)
FM (kg)	23.5 ± 10.4 (17–39)
ADL score	4.6 ± 2 (0–6)
IADL score	9.02 ± 6.8 (0–17)
MMSE score	23.8 ± 6.5 (1–30)
GDS score	5.7 ± 4.6 (0–15)
Hand grip (kg)	22.37 ± 8.0 (0–38)
4-m gait speed (sn)	7.22 ± 1.5 (4–10)

PP-53

THORACOLUMBAR JUNCTION SYNDROME WITH LEFT LOWER ABDOMINAL PAIN

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Introduction: Thoracolumbar junction syndrome (TLJS) is a result of dysfunction at the thoracolumbar junction and is generally referred as low back pain. TLJS includes multipl painful conditions like pseudovisseral low abdominal, pubic and inguinal pain (1). Patients generally don't describe pain in the thoracolumbar junction. Due to the variety of clinical manifestations TLJS can often be confused with other pathologies and may result in misdiagnosis and the application of improper treatments (2.3). Diagnosis is based on clinical evaluation (4).

Case: A 89 year old woman, has been followed up with hypertension, ischemic heart disease and atrial fibrillation for 15 years. She had been suffering from left lower abdominal and low back pain for eight months. There wasn't any pathologic finding in abdominal-MR and abdominal CT angiography while hiatal hernia and antral gastritis were found in gastroscopy in her recurrent gastroenterology consultation. Percutaneous transluminal coronary angioplasty (PTCA) was performed and stent was inserted to distal circumflex on the elevation of troponin value while examining the cause of abdominal pain. She admitted to our clinic for her continuing complaints. On her physical examination TA: 110/90 mmHg, pulse: 90/min, arryhytmic, S1, S2 (+); S3, S4 Ø. There was sensitivity with deep palpation in the left lower abdomen without rebound and defenses. Laboratory findings are on table-1. There was 5.175 gr/day proteinuria in the 24-hour urine. IgG Lambda myelom was detected in serum immunoelectrophoresis with M spike on protein electrophoresis. The patient refused the treatment for myeloma. Paraspinal tenderness was observed while assesing bone sensitivity. Diffuse bulging was observed at L3–4,

L4–5, L5-S1 levels with neural foramen narrowing in lomber MR. In cervicothoracal MR, neural foramen constriction and bulging was observed at dorsal osteophytes at T1–2 and T10–11 levels. Left T12-L1 facet joint was painful by compression on physical examination of the patient consulted with physical medicine and pain was spreading to left lower quadrant of the abdominal and inguinal region. Left iliac crest was sensitive and painful to the right (positive iliac crest test). T12 push test was positive. Betamethasone and lidocaine was injected to the left T12-L1 facet joint. In the follow-up examination after the injection, the abdominal pain of the patient has disappeared with negative physical examination tests and did not recur again.

Discussion: TLJS is frequently overlooked in differential diagnosis. Patients may be exposed to unnecessary diagnostic interventions and surgery (2). In our case despite many investigations and treatment protocols has been performed including PTCA and her complaints were completely resolved after a simple injection. The diagnosis is made with clinical suspicion and clinical evaluations; so we should keep in mind thoracolumbar junction syndrome.

Keywords: Thoracolumbar junction syndrome, abdominal pain.

Table 1. Initial laboratory tests

WBC	8300	IgM	29.2 mg/dl
Hgb	11.9 gr/dl	IgA	54.6 mg/dl
Htc	% 34.7	IgG	1048 mg/dl
Plt	270000	Beta-2-microglobulin	3850 ng/ml
Urea	62 mg/dl	CRP	1 mgr/L
Creatinine	0.84 mg/dl	Sedimentation	57 mm/hr
Na	139 mmol/L	LDH	157 IU/L
K	4.78 mmol/L	PTH	39.2 pg/ml
Ca	8.16 mg/dl	25-OH-D vit	7.7 µg/L
P	3.9 mg/dl	Albumin/Globulin	2.41/4.4 gr/dl
Uric acid	4.6 mg/dl	ALP/GGT	52/26 U/L
D. Bil/I. Bil.	0.11/0.28 mg/dl	AST/ALT	33/31 IU/L

PP-54

THE EFFECT OF DIZZINESS ON BALANCE AND QUALITY OF LIFE IN ELDERLY

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Objectives: World health organization defined elderly period as 65 age and older is old and 85 age and older is very old. The aim of our study is to compare the effect of dizziness on balance and life quality in elderly and people under 65 age

Materials-Methods: 603 patients who admitted to Vertigo Clinics at Istanbul Faculty of Medicine, Department of Physical Medicine and Rehabilitation with complain of dizziness were included in our study. Patients ages, duration of dizzines, quality of dizziness and frequency of attacks were questioned. After history and physical examination, quality of life was assessed with Dizziness Handicap Inventory (DHI) and balance ande risk of fall were assessed with Berg Balance Scale (BBS).

Results: 603 patients who admitted to Vertigo Clinics at Istanbul Faculty of Medicine, Department of Physical Medicine and Rehabilitation with complain of dizziness were included in the study. 66.9% of patients were female and 33.2% were male. Patients under 65 were 507 (Group 1), patients older 65 were 96 (Group 2). Those under age of 65 admitted to our clinic were statistically significantly higher. Median age in Group 1 and Group 2 were 45.4±11.7 and 71.9±4.8 years.

There was no statistically significant difference between the quality of dizziness and frequency of attacks. The duration of attacks were statistically significantly longer in Group 2 to Group 1 ($p<0.01$). Mean DHI score and mean BBS scores of group 1 were 47.5 and 53.5 respectively as mean DHI score and mean BBS scores of group 2 were 44.7 and 47.5 respectively. There was statistically significant differenc between DHI and BBS scores of group 1 and group 2. ($p<0.01$)

Conclusion: Dizziness effects quality of life in younger people more than elderly**.** The duration of dizziness is longer in older people and causes more balance disturbance

Keywords: Dizziness, elderly, quality of life, balance

PP-55

THYROID FUNCTION TESTS IN TURKISH GERIATRIC POPULATION

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Background: Normal range of thyroid function tests in the elderly population is still controversial. In this study, we tried to find out the normal ranges of thyroid function tests in Turkish older patients without having any type of thyroid disorders.

Methods: FT4, FT3 and TSH, anti-thyroglobulin (antiTG) and thyroid peroxidase antibody (anti-TPO) levels were measured by DxI 800 (Beckman Coulter Diagnostics, USA). The new set up TSH immunoassay was used in the study which shows better analytical sensitivity at low TSH concentrations, compared to the old method. Individuals with antiTPO>9 IU/mL and antiTG>4 IU/mL were excluded and 122 individuals over 65 years old without any known thyroid disorder composed the study group. The statistical analysis was performed by using IBM SPSS software, version 21 (SPSS Inc., Chicago, IL, USA) and MedCalc version 14.8.1 (Mariakerke, Belgium). Statistical significance was assumed when the p-value was <0.05. All results were expressed as mean±standard deviation (SD). Independent sample t test was used for the comparison of TSH, FT4 and FT3 values in gender and age group (65–75 and >76). Outliers were tested with the D'Agostino-Pearson test. The reference intervals were calculated with reference interval for normal distribution.

Results: The prevalence of antiTPO positivity was 8.3% and AntiTG positivity was 5.8% in our study group. In 2.5% of the individuals, both antibodies were out of the normal range. Age-specific geriatric reference ranges for TSH, FT4 and FT3 were determined after the exclusion of these individuals. At 2.5th lower limit (CI) and 97.5th upper limit (CI), the age-specific TSH range was 0.33 [0.28–0.39] mIU/mL and 3.99 [3.35–4.76] mIU/mL, mean±SD was 1.35 ± 0.79 mIU/mL, respectively. For FT4 mean±SD was 12.79±2.49 pmol/L, reference range was 7.86 [7.15–8.57] pmol/L and 17.85 [17.14–18.55] pmol/L. For FT3, mean±SD was 4.30±0.85 pmol/L, reference range was 2.57 [2.32–2.81] pmol/L and 6.02 [5.77–6.26] pmol/L. According to the Beckman Coulter system, TSH, FT4 and FT3 reference values for individulas between 18–65 years were 0.38–5.33 mIU/mL, 7.86–14.41 pmol/L and 3.8–6.0 pmol/L, respectively.

Conclusion

We have found in this study that thyroid function tests (TSH, FT4 and FT3) of Turkish older population were in reference ranges used

for the patients aged between 18–65 years. Further studies including large number of participants are needed.

Keywords: Thyroid, function, older

PP-56

INCIDENCE OF HEALTHCARE-ASSOCIATED INFECTIONS IN ELDERLY >65 YEARS AND ADULTS <65 YEARS OF AGE IN AN INTENSIVE CARE UNIT

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Introduction: The aim of this study was to investigate the incidence of healthcare-associated infections in elderly patients who were treated in the intensive care unit (ICU) and to classify the types of infections together with a comparison to the adult patients <65 years of age in the same time period.

Materials and Method: A total of 823 patients who were treated in the ICU from January 2015 to the end of December 2016 were included. The ICU was a mixed unit where medical and postoperative patients were followed. Healthcare-associated infections were determined according to the updated criteria of Centers of Disease Control (CDC). A total of 405 (49.2%) of the patients were in the elderly group (> 65 years of age), while 418 were aged between 18 to 65 years. Two groups were compared according to the types of infections and causative microorganisms.

Results: During the 2-year period, a total of 17 healthcare-associated infections were dedected from which 11 were (65%) in the geriatric group. The overall incidence of healthcare-associated infections in the ICU was 4.81/1000 patient-days. Among 405 geriatric patients'ICU admissions, healthcare-associated infections developed at a rate of 2.7%. Whereas the rate for the group 18–64 years was 1.4%. Among the 11 infections in the geriatric group 4 (36%) were primary bloodstream infections of which 75% were central catheter associated. Four infections were lower respiratory tract infections of which 25% were ventilator associated, 1 (9%) was a urinary catheter-associated urinary tract infection, 1 was a gastrointestinal system infection and 1 was a skin&soft tissue infection. Resistance pattern of the 18 microorganisms isolated were as 1 extended-spectrum beta-lactamase producing Klebsiella pneumoniae, 1 methicillin-resistant S. aureus, and 1 multidrug-resistant Acinetobacter baumannii, and 2 carbapenemase-producing Pseudomonas aeruginosa. During the 2-year period in the ICU there was no significant difference between the elderly and adult groups regarding in the development of healthcare-associaed infections (p> 0.05).

Conclusion: Intensive care units are services where healthcare-associated infections are found to have higher incidence rates. In this study no significant difference was found beween the geriatric age group and the 18–65 year aged group but longer periods of observation is needed.

Keywords: Intensive care unit, Healthcare-associated infection, Geriatric patient

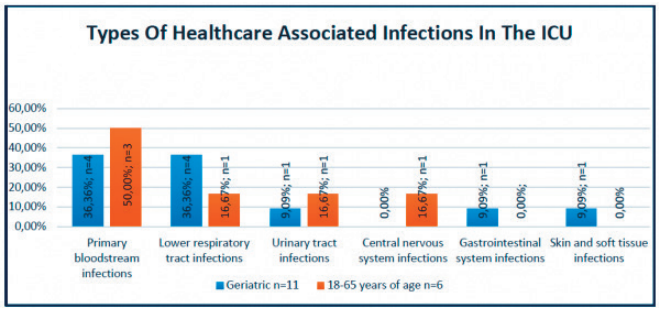

Figure 1.

Table 1. Number of patients and rate of infections in the ICU between 01.01.2015–31.12.2016

	Number of patients	*Healthcare-associated infection*	*Healtcare-associated infection rate (%)*
>65 years of age	405	11	2.72%
Aged 18–65 years	418	6	1.44%
Total	823	17	2.07%

Table 2. Isolated Microorganims in the ICU in groups aged > 65 and aged 18–65 years

Microorganism	*> 65 years n (%)*	*Aged 18–65 years n (%)*	*Total*
Klebsiella pneumoniae	1 (8.33)	2 (33.33)	3 (16.67)
Enterococcus spp	3 (25)	0	3 (16.67)
P. aeruginosa	1 (8.33)	1 (18.67)	2 (11.11)
Enterobactericae spp	2 (16.67)	0	2 (11.11)
S. aureus	1 (8.33)	1 (16.67)	2 (11.11)
Candida spp	1 (8.33)	1 (16.67)	2 (11.11)
E. coli	0	1 (16.67)	1 (5.55)
S. marcescens	1 (8.33)	0	1 (5.55)
A. baumannii	1 (8.33)	0	1 (5.55)
Clostridium spp	1 (8.33)	0	1 (5.55)
Total	12 (100)	6 (100)	18 (100)

PP-57

AN ELDER PERSON WHO ADMITS TO EMERGENCY DEPARTMENT WITH "FEELING SLIGHTLY BAD"

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Introduction: In geriatric population, symptoms and signs may be obscure, even in lifethreating events. Many nonspecific complaints can be manifestations of serious health problems or the presentations may be atypical.

Case: 74 years old female patient was admitted to emergency department with "feeling slightly bad" in last 15 days. When she was asked any other complaint beside "feeling slightly bad", she told some others like fatigue, dizziness headache, general body pain and bitter water coming from her mouth. She had gone to gastroenterology specialist, reflux treatment was started. During this period, he felt a little bit shortness of breath while she was walking. In phsysical examination there is no any abnormal finding. She was cooperated, Blood Pressure: 110/65 mmHg, Heart Rate: 56/Rhytmic, Respiratory Rate: 18/minute, Temperature: 36.5, Oxygen Saturation:% 96. In laboratory; Leukocytes: 7.7, Hb: 14.1, Platelet: 253, CRP: 3.1, Kreatinin, CK, CK-MB, Troponin levels were in normal ranges, D-Dimer>5 ug/

MI, (n<0.75), in her story she had overcyst excision, fibrocyst excision form breast, diverticulitis and she had reflux, glucose intolerance, osteoporosis, policystic kidney. Her thorax computerised tomography imaging reveals that pulmonary thromboemboli in inferior lobe posterior ve anterior segment, medial lobe medial segment, superior lobe anterior segmentin right lung and in inferior lobe anterior segment in left lung. She was hospitazied and started medication.

Discussion: Pulmonary thromboli-embolism is a life threating and serious situation. 3. leading death cause in all cardiovascular events it can be fatal in acute or chronic period, there are some serious predisposing factors like fracture in lower extremities, atrial flutter/fibrilation, hip or knee surgery, major trauma, myocardial infarction, previous venous thrombo-emboli or spinal cord damage, moderate predisposing factors autuimmune diseases, in vitro fertilization, blood transfusion, chemotherapy, oral contraceptives, congestive heart or respiratory diseases or mild predisposing factors like immobility (airplane or bus travels), pregnancy, elderly, laparoscopic surgery, obesity. In our patient, there is just age factor of these predisposing factors. Symptoms are dispne, cough, chest or back pain, hemoptysis but again in our patient there was just a little bit dispnea just while she was walking, even in such a wide emboli. In elderly people it can be estimate that because of phsyiological changes of aging and co-morbidities facilitate the symptoms but in our patient all biochemical markers (except D-Dimer) were in normal ranges and also D-Dimer is a nonspecific parameter. This patient remind us in a geriatric patient there are no absolute rules, presentations may be atypical even if in serious acute-subacute and chronic health problems as seen in this case. In an elder person, all complaints requires more carefully evaluation and it must be kept in mind that deteriration can be more speedly than the younger peoples.

Keywords: atypical presentation, pulmanary emboli, feeling bad, elderly

PP-59

DEPENDENCY LEVELS AND QUALITY OF LIFE FOR ELDERLY PEOPLE LIVING IN NURSING HOMES

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Akdeniz Üniversity

Nursing Homes are an organizational caring model that meets the fundamental needs of older adults who are not able to fulfill their lives on their own.

Aim: Our study is planned in an effort to determine the dependency levels and quality of life for elderly people living in nursing homes

Method: The study designed in a cross sectional descriptive method has been conducted with 109 older adults in 5 senior cent **nursing homes** ers in Antalya, Turkey. The Institutional Review Ethics Boards at Akdeniz University Hospital approved the study and a written consent was obtained from administrations of the centers and the older adults before the practice. The data of the study was collected by face-to-face interview method with the older adults that meet the inclusion criteria. In order to collect the data, the elderly introduction form focusing on the questions about the erderly's sociodemographic characteristics, health and lives in the senior centers, WHOQOL BREF-TR scale and Barthel Index were used.

Results: In our study, we include 109 older adults maintaining their lives in the senior centers. The average age of the participants is 73.92±9.36 years (50–96) and 60.6% of them were male, 62.4% of them were widowed and 82.6% of them have children. The average duration of stay in the senior centers is 3.61±3.22 years (1–15). 44.0% of the elderly attained to only primary education and 18.3% of them were illiterate. 51.4 of the elderly had equal income and expense levels. The rate of chronic illnesses in the elderly is 67.0%. WHOQOL BREF-TR physical subscale score average is 66.51±22.58, psychological subscale score average is 66.32±20.68, social subscale score average is 52.90±20.86, environmental subscale score average is 67.94±18.00, national environmental subscale score average is 62.33± 15.62. Barthel Index score average is 89.35 ±21.39.

Keywords: Dependency Levels, Quality of Life, Elderly, Nursing Homes

PP-60

ASSOSIATION BETWEEN POTENTIALLY INAPPROPRIATE PRESCRIPTION AND RATES OF HOSPITALIZATION

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Objective: The geriatric patient population now accounts for about half of the hospitalized patients. The aim of this study to investigate the clinical relevance of potentially inappropriate prescriptions, identified by the STOPP/START criteria, and hospitalization rates.

Methods: This was a cross-sectional study. A total of 342 patients over 64 years hospitalized at university hospital were included in this study. The paticipants's age, gender, medical history, medication used and the number of hospitalizations in the last 1 year were recorded and the STOPP/START criteria (version 2) toolkit was applied. The obtained data were evaluated with SPSS 18.0 statistical data program.

Results: The mean age was 72±6.2 years and 55% of patients were female. The average number of illnesses was determined as 2.08 (lowest 0, highest 8). The median number of medications per patient was 4.8 drugs (lowest 0, highest 15). The prevalence of potentially inappropriate medication prescribing (PIM) was 25.7% according to STOPP versions 2 and potential prescribing omission (PPO) was calculated 65.8%, using START v2. The mean number of patients hospitalized in the last 1 year was 1.43 (lowest 0, highest 5). We found a positive correlation (r=0.194 p=0.000) between the number of hospitalizations in the last year and inappropriate prescription according to the STOPP criteria v2 and prescribing medicines that are ignored according to START criteria v2 (r=0.211 p=0.000).

Conclusion: Inappropriate medication prescribing in older adults has become a public health problem due to its high prevelance, associated undesirable effects, and increased costs. One of the practical guidelines to reduce inappropriate drug use is the STOPP/START criteria. In our study, we found that inappropriate drug use and the use of blinded drug had a significant effect on the number of hospitalizations.

Keywords: hospitalization rates, STOPP/START criteria (version 2)

PP-61

ASSESSING POTENTIALLY INAPPROPRIATE PRESCRIBING IN OLDER PATIENTS USING THE UPDATED VERSION OF STOPP/START CRITERIA V2.

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Objective: Polypharmacy is defined simply as the use of multiple medications by a patient. The precise minumum number of medications used to define 'polypharmacy'is variable, but generally ranges from four and over (5 to 10). The aim of this study to investigate the incidence of polypharmacy rates and inapproppriate drug usage in geriatric patients.

Methods: A total of 342 patients over 64 years hospitalized at university hospital were included in this study. The paticipants's age, gender, medical history and medication were recorded and the STOPP/START criteria (version 2) toolkit was applied. The obtained data were evaluated with SPSS 18.0 statistical data program.

Results: The mean age was 72±6.2 years and 55% of patients were female. The average number of illnesses was determined as 2.08 (lowest 0, highest 8). The median number of medications per patient was 4.8 drugs (lowest 0, highest 15). The prevalence of potentially inappropriate medication prescribing (PIM) was 129 (% 37.6) according to STOPP versions 2 and potential prescribing omission (PPO) was calculated 65.8%, using START v2. Distribution according to subgroups is shown in the table.

Conclusion: Inappropriate medication prescribing in older adults has become a public health problem due to its high prevelance, associated undesirable effects, and increased costs. One of the practical guidelines to reduce inappropriate drug use is the STOPP/START criteria. In this study, According to STOPP v2 criteria, we found that the level of inappropriate drug use was much lower than the European average (51.3%) in comparison with similar studies conducted by external centers. However, we found that the level of medicines neglected was somewhat above the European average (59.4%) according to START v2. (1)

References

1. Gallagher et al Clinical Pharmacology & Therapeutics 2011

Keywords: STOPP/START criteria (version 2), Potentially Inappropriate Prescribing

Table 1.

START-Subgroups	*Potentially inappropriate medication prescribing (PIM)*
CARDIOVASCULAR SYSTEM	188
CENTRAL NERVOUS SYSTEM	4
MUSCULOSKELETAL SYSTEM	26
ENDOCRINE SYSTEM	63
GASTROINTESTINAL SYSTEM	1
RESPIRATORY SYSTEM	26
UROGENITAL SYSTEM	4

PP-62

IMPACT OF STOPP/START CRITERIA ON FALL RISK AMONG THE HOSPITALIZED ELDERLY PATIENTS

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Objective: Falls can happen in all age groups, but they especially occur in 1/3 of elders aged 65 or above, and about% 50 of elders who have experienced falls experience recurrences, and 10% of the falls result in serious injuries. Polypharmacy is an independent risk factor for falls. Inappropriate drug use as much as polypharmacy in the elderly is also important because it leads to various side effects and drug drug interactions. We aimed to investigate the effect of inappropriate drug use on the risk of falls in this study.

Methods: A total of 342 patients over 64 years hospitalized at university hospital were included in this study. The paticipants's age, gender, medical history and medication were recorded and the STOPP/START criteria (version 2) toolkit was applied. The inpatients were assessed for fall risk using the Hendrich 2 fall risk model

(HFRM) at admission. The obtained data were evaluated with SPSS 18.0 statistical data program.

Results: The mean age was 72±6.2 years, and 55% of patients were female. The average number of illnesses was determined as 2.08 (lowest 0, highest 8). The median number of medications per patient was 4.8 drugs (lowest 0, highest 15). According to the Hendrich 2 fall risk scale of patients, 104 (30.4%) were in low risk and 238 (69.6%) were in high risk group. There was no significant correlation between falling risk and appropriate prescriptions, identying by STOPP/START criteria v2. (START p: 0.^{196} STOPP p: 0.134)

Conclusion: Inappropriate medication prescribing in older adults has become a public health problem due to its high prevelance, associated undesirable effects, and increased costs. One of the practical guidelines to reduce inappropriate drug use is the STOPP/START criteria. The sample size is relatively small and large numbers of subjects are needed to determine whether does STOPP/START criteria relate to falling risk.

Keywords: STOPP/START criteria, fall risk

Table 1.

Hendrich 2 fall risk model	*low risk Mean*	*high risk Mean*	*p-value*
STOPP criteria	0.67	0.52	0.134
START criteria	1.38	1.20	0.196

PP-63

INAPPROPRIATE PRESCRIPTIONS IN OLDER ADUTS-ASSESSING THE QUALITY OF LIFE USING SF 36

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Objective: Within elderly people, large quality-of-life differences exist. The proportion reporting problems was rising within creased age, as was also the proportion of individiual problems in more than one scope. The number of chronic illnesses and drug usage in creases and the quality of life decreases. Our aim was to analyse the influence of appropriate prescriptions rates on the life quality.

Methods: A sample of 342 older adults (in geriatrics clinic) were included in the study. The 36-item short-form health survey (SF-36) was used to assess health-related quality of life (HRQoL). Patients completed the SF-36 questionnaire and the STOPP/STARTcriteria (version 2) was applied to all them.

Results: The mean age was 72±6.2 years and 55% of patients were female. The average number of illnesses was determined as 2.08 (lowest 0, highest 8). The median number of medications per patient was 4.8 drugs (lowest 0, highest 15). The assosiation between quality of life and STOPP/START criteria was shown in the table. In our study, it was found that SF-36 quality of life scale was weak correlation with FF (physical function) subgroup by inappropriate drug prescription according to START/STOPP criteria v2. It was also found that SF-36 quality of life scale with START criteria was weak correlation between FRK (physical role limitation) and pain subgroup. The STOPP criteria and the SF-36 quality of life scale were found to be weak correlation with the subscales of Mental Health and Social Functioning

Conclusion: Inappropriate medication prescribing in older adults has become a public health problem due to its high prevelance, associated undesirable effects, and increased costs. One of the practical guidelines to reduce inappropriate drug use is the STOPP/START criteria. We did not find any significant relationship between quality of life and STOPP/START criteria except for some subgroups. The sample size is relatively small and large numbers of subjects are needed to determine whether does STOPP/START criteria relate to life of quality.

Keywords: Quality Of Life, Stopp/Startcriteria (Version 2), geriatrics

Table 1.

SF-36 LIFE QUALITY SCALE	*CORRELATION WITH START CRITERIA (With p value)*	*CORRELATION WITH STOPP CRITERIA (With p value)*
PHYSICAL FUNCTION	0.006 (r=-0.149)	0.015 (r=-0.132)
PHYSICAL ROLE LIMITATION	0.024 (r=-0.122)	0.197
EMOTIONEL ROLE LIMITATION	0.100	0.452
ENERGY, LIVING AND ZINC	0.728	0.805
MENTAL HEALTH	0.089	0.006 (r=-0.149)
SOCIAL FUNCTIONING	0.603	0.015 (r=-0.132)
PAIN	0.022 (r=-0.124)	0.088
GENERAL HEALTHCARE	0.167	0.504

PP-64

THE EFFECTS OF FEAR OF FALLING IN ELDERLY ON TIMED LIMB COORDINATION AND WALKING SPEED

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Background and Purpose: Fear of falling (FOF) and falls are common in the elderly population and may result in injuries, limitation of physical activities such as walking, loss of independence and decreased psychological functioning. In literature limb coordination performance attenuated the effects of gender, age and body mass index on walking speed in elderly. In absence of defined pathology, it is less clear how fear of falling effects timed limb coordination and walking speed in elderly. The purpose of this study was to examine the effect of fear of falling on timed limb coordination and walking speed.

Material and Method: The community-dwelling older people (65 and older) were recruited from different social senior groups and from the Hacettepe University Hospital Geriatric Clinic. Fifty two patients were evaluated. We used a standardized questionnaire, consisting of sociodemographic datas, cognitive function, and history of falls during the previous year. Preferred and maksimum walking speeds were measured during Six Meter Walk Test. To assess limb coordination performance, a battery of 2 upper extremity tests and 1 lower extremity test was used for dominant limb. For upper extremity during a timed 5-repetition finger to nose and pronation and supination was used. For lower extremity during a timed 5-repetition heel on shin test was used. Fear of falling of elderly people was assessed by a question (Do you have fear of falling? Yes/no).

Results: In this study, 18 (34.6%) male and 34 (65.4) female older people participated in the study. The average age of the individuals is 74, 51 ± 5.47. Older people were divided two groups have fear of falling (n: 24) and have no fear of falling (n: 28). There were no difference between groups in age, gender ($p>0.001$). When we compare the scores of timed limb coordination and walking speed in eldery have no fear of falling were better than who have fear falling. ($p<0.001$).

Conclusion: As aresult of study the fear of falling is one of the most important barrier to limb coordination, walking speed. So that in older people who have fear of falling have effected activities of daily living and instrumental activity, physical performance and quality of life.

PP-65

RELATIONSHIP BETWEEN UPPER LIMB COORDINATION, WALKING SPEED, PHYSICAL PERFORMANCE AND INSTRUMENTAL ACTIVITIES OF DAILY LIVING IN OLDER ADULTS

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Background and Purpose: Walking performance is a hallmark of physical function and physical performance. One's preferred walking speed, for example, reflects quality of life and health status and predicts cognitive decline and remaining life expectancy in older adults. In addition to preferred walking speed, maximum walking speed may also be important. Maximum walking speed declines more rapidly than preferred walking speed in older adults, due in part to age-related changes in neuromuscular control. Therefore, assessing maximum walking speed may provide advantages over preferred walking speed for detecting functional decline. It is unclear, however, relationship among timed upper limb coordination, walking speed, physical performance and instrumental activities of daily living. Therefore; the purpose of this study was to examine the relationship among timed limb coordination, preferred, maximum walking speed, physical performance and instrumental activities of daily living.

Material and Method: The community-dwelling older people (65 and older) were recruited from different social senior groups and from the Hacettepe University Hospital Geriatric Clinic. Fifty two patients were evaluated. We used a standardized questionnaire, consisting of sociodemographic datas, cognitive function, and history of falls during the previous year. Physical performance was evaluated with Short Physical Performance Test (SPPT). Preferred and maksimum walking speeds were measured during Six Meter Walk Test. Upper limb coordination performance was measured during a timed 5-repetition finger-to-nose test for dominant limb. Activities of daily living (ADLs) were measured by using Lawton score for Instrumental Activities of Daily Living (IADLs). Correlation analyses were used to examine the relationship among upeer limb coordination performance walking speed, physical performance and instrumental activities of daily living.

Results: In this study, 18 (34.6%) male and 34 (65.4) female older people participated in the study. The average age of the individuals is 74, 51 ± 5.47. There was negative correlation upper limb coordination between SPPT (r:-0.847 p<0.001) and instrumental activities of daily living (r:-0.323, p<0.001) there was positive correlation between upper limb coordination and preferred (r: 0.613 p<0.001) and maksimum walking speed (r: 0.439 p: 0.001).

Conclusion: The findings that upper limb coordination performance would correlate with walking speed and physical performance in healthy older adults. If upper limb coordination was affected by age, this have effected physical performance and instrumental activities of daily living. Upper limb coordination may be a modifiable determinant of walking speed, physical performance and instrumental activities of daily living in older adults. In elderly population walking speed and physical performance are important in terms of quality of life and activities of daily living. So that upper limb coordination may be a potentially modifiable marker of neuromuscular control that predicted maximum walking speed, physical performance in older adults.

ULUSLARARASI AKADEMİK GERİATRİ KONGRESİ

2017

CASE PRESENTATIONS

CP-01

AN INTERESTING CASE OF INABILITY TO VOID FOR AN ELDERLY WOMAN: CLOSED VAGINA

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A 69-year-old female patient was admitted to our center with the complaint of inability to void. She said that her complaint increased over time, and that the flow of her urine decreased considerably and finally stopped completely. In regard of gradually decreasing flow of urine and its final stop initially, we thought it was urethral stricture.

Urinary ultrasonography showed that her bladdder was full to the maximum capacity and she developed glob vesicle, which was confirmed by ultrasonography. The physical examination produced an interesting result because we realised that there was no vagina and no urethral external mea. Instead of the vaginal area, a structure which resembled a vertical incisional line was detected. We assumed that this line occured by the adhesion of the labium majus of the vagina. In order to empty the bladder with a urethral catheter we failed to open this vaginal adhesion by hand because the all tissues were adhered.

Then we took her medical history which revealed that she never married or never had a sexual intercourse. After that we decided to make an examination in lithotomy position in the operating room and to open the vagina by the surgery to find out the external urethral mea.

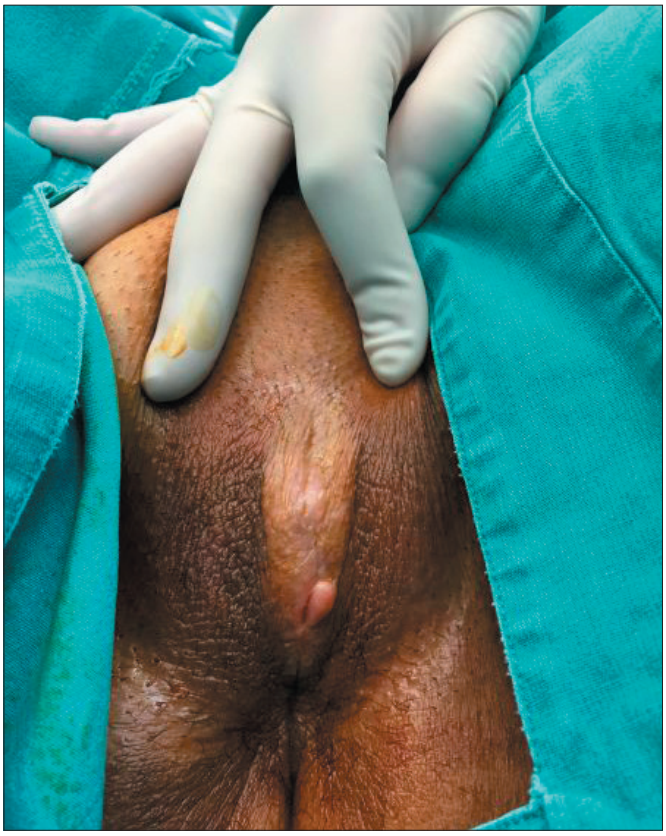
However, an interesting situation was encountered at this stage. The patient said that she was virgin and demanded that her treatment be given without damage to her virginity.

With local anesthesia, the presumably upper urethral site was opened nearly 1 centimetre with a clamp. From this open site, urethra protruded and a little amount of blocked urine came; however, the bladder did not discharge. After that we inserted a 5F metallic cervical dilatator from the open side and found the urethral external mea blindly. Then we pushed the 5F metallic dilatator into the bladder.

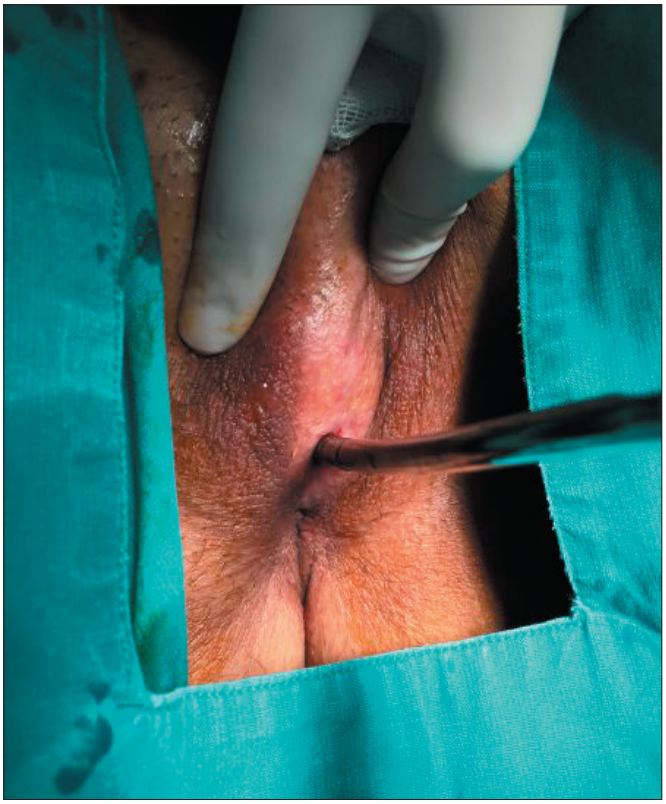
When we removed the metallic dilatator, all the urine came through this canal and the bladder was empty.

There may be a lot of causes for the elderly female patients to be unable to urinate but ours is a unique case in literature.

Keywords: closed vagina, glob vesicle, vaginal adhesion, elderly woman



Picture 1. closed vagina in lithotomy position.



Picture 2. opened vagina with 5F metallic servical dilatator in lithotomy position.

CP-02

A 100-YEAR-OLD ELDERLY WITH CHRONIC HYPONATREMIA DETERIORATED WITH URINARY TRACT INFECTION

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Introduction: Patients with comorbid chronic diseases are more prone to have electrolyte imbalances but the vulnerable population like the geriatric age group have more frequent hospital admissions due to clinical deterioration with various causes. Here we present an old patient who has hyponatremia for several years but was admitted to the hospital with hyponatremia together with bacteremia secondary to catheter-associated urinary tract infection which started with vomiting.

Case presentation: A 100-year- old woman was admitted to the hospital with fever, severe vomiting and impaired cognitive function present for the last 2 days. Her caregiver admitted that the patient did not have diarrhea. Her past medical history included hypertension, chronic renal failure, hypothyroidism, Alzheimer's disease and Sleep apnea syndrome. She was diagnosed with a subdural hematoma 7 years ago and was bedridden since then. Her enteral feeding was established via a percutaneous endoscopic gastrostomy (PEG) tube for the last 6 years, and a urinary catheter was used because of her immobilization. She had frequent hospital stays during the last year for various reasons. Her medications included L-thyroxin, metoprolol, amlodipine-valsartan and pantoprazole. Her physical examination revealed fever as 38.1°C, blood pressure to be 136/70 mmHg. She was uncooperative and murmured meaningless words to tactile stimuli. There was mild seropurulent discharge around the PEG tube. The urine appeared cloudy inside the urinary catheter. Laboratory findings showed leukocytosis of 16.000/mL, CRP 4.2 mg/dl, creatinine 2.09 mg/dL, albumin 3.4 g/dL, serum sodium 126 mmol/L, urine sodium 24 mmol/L. Blood culture was reported as ESBL-producing *E.coli*; urine culture as ESBL-producing *E.coli* and *Pseudomonas aeruginosa*; swab culture taken around the PEG tube revealed *Enterobacter cloacae* and *Enterobacter aerogenes* growth. Three weeks ago her serum sodium level was 136 mmol/L which was within the normal range. The patient was diagnosed as bacteremia secondary to urinary tract infection, peristomal wound infection around the PEG tube, acute on chronic renal failure and hyponatremia. Her infection was treated with meropenem according to the culture antibiogram report; hyponatremia was corrected with sodium replacement and the PEG tube was changed. The patient became afebrile and serum sodium levels became normal on the 4th day of replacement therapy. After 5 weeks she became cooperative although her responses were with few words, and received daily salt tablets for her chronic hyponatremia.

Discussion: Urinary tract infection can present with vomiting which may further lower sodium level in patients who are prone to have electrolyte imbalance. Elderly patients who have hyponatremia due to chronic diseases like chronic renal failure, hypothyroidism or syndrome of inappropriate ADH secretion who suffer an infection should be controlled for electrolyte disturbances

Keywords: Hyponatremia, Urinary tract infection, Elderly

CP-03

MAGNUSIOMYCES CAPITATUS : A RARE CAUSE OF PNEUMONIA

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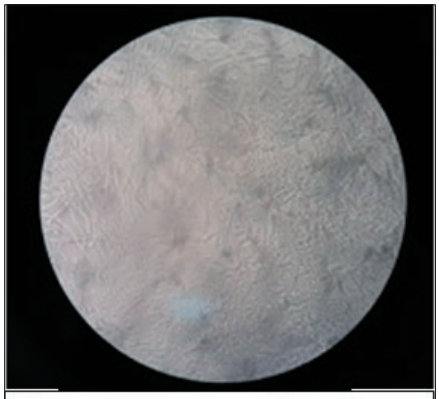
Introduction: Pneumonia is an important cause of morbidity and mortality in elderly patients. As infectious pneumonia may be more likely to be due to bacterial agents, viruses and fungi can also cause pneumonia. *Magnusiomyces capitatus* (teleomorph form of *Saprochaete capitata*, previously named*Geotrichum capitatum*, *Trichosporon capitatum* or *Blastoschizomyces capitatus*) should be kept in mind as a rare cause of pneumonia that is widespread in nature and can colonize skin, respiratory and gastrointestinal tract mucosa.

Case report: A 93-year-old male patient was admitted with cough, sputum and confusion which has started 3 days ago. He had no medical history except diabetes mellitus and stroke. On admission fever 36.7 ^{0}C, heart rate 135/minute, blood pressure 120/75 mmHg were measured. There were rales in his physical examination, also there was consolidation at his chest X-ray. His electrocardiography was compatible with atrial fibrillation. His leukocyte, hemoglobin and thrombocyte counts were 11,2x10^9/l (neutrophil: 9,9x10^9/l vs. lymphocyte: 0,7x10^9/l), 13,5 g/dl and 164x10^9/l, respectively. There were no abnormalities with kidney and liver function tests except sodium levels (154 meq/l). C-reactive protein (CRP) and sedimentation levels were 212 mg/dl and 66 mm/h, respectively. We started empirical intravenous levofloxacin therapy with diagnosis of pneumonia. Consecutive tracheal aspirate cultures revealed *Magnusiomyces capitatus* colonization with increasing colony counts. *M. capitatus* was identified on the basis of colony morphology, microscopic morphology on Corn Meal Tween 80 Agar and MALDI-TOF mass spectrometry (Bruker, Germany). Detection of galactomannan antigen in tracheal aspirate fluid (0,9 ng/ml) supported the diagnosis. Intravenous Amphotericin B was added to the current treatment and after 10 days of treatment, the patient's CRP and leukocyte levels were decreased. Also hypernatremia was solved too with intravenous liquid repletion. No pathogenic microorganisms were detected in tracheal aspirate culture after the treatment.

Conclusion: *Magnusiomyces capitatus* is a rare pneumonia agent, with a high mortality rate (>%50). Although it has been previously reported in the pleural fluid, we found it in tracheal aspirate culture. Because of its high mortality rates we recommend that clinicians should take this agent into account, especially in cases of pneumonia that does not respond to antibiotic therapy.

Keywords: Magnusiomyces capitatus, pneumonia

Macroscopic appearances of *M.capitatus* colonies on 5% Sheep Blood Agar



Microscopic appearance of *M. capitatus* on Corn Meal Tween 80 Agar (X40)

CP-04

ARE WE AWARE OF IMMUNODEFICIENCY DUE TO GLUCOCORTICOID USE?

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Purpose: Glucocorticoids have inhibitory effects on a broad range of immune responses and systemic glucocorticoid therapy is associated with an immediate increase in the risk of infection. Infection risk might be directly related to glucocorticoid dose or there may be some inhibition of adaptive immune responses with increasing duration of therapy. We have wanted to attract attention to immunodeficiency due to glucocorticoid use because of one of our patients who had used corticosteroid for four years due to pre-diagnosis of autoimmune hemolytic anemia and suffered from opportunistic infections.

Case: 67 year old man was hospitalized due to high fever. Physical examination: The blood pressure 90/70 mm Hg, temperature 38, 5 °C. There were crackles at the lung bases and liquid collection beside the left olecranon. The remainder of the examination was normal. He had history of diabetes mellitus and penicillin allergy. He had used methylprednisolone four years for pre-diagnosis of autoimmune hemolytic anemia intermittently. It was learned that he was hospitalized many times due to anemia, thrombocytopenia and fever attacks. The complete blood count, WBC: 4.25 103/μL, Hb:8,6 g/dl, MCV:101 fl, rdw:%19,6, platelet level:74000/μL, erythrocyte sedimentation rate : 74 mm/h, C-reactive protein: 5,5 mg/dl, the other results of tests were normal. A chest radiograph reportedly showed bilateral ground glass opacities especially in apical lobes. Although he was given fluoroquinolone, there was progression of ground glass opacities, so bronchoscopy was performed. Broncho alveolar lavage fluid sample culture grew Candida albicans and fluid culture beside olecranon grew acid resistant basil Mycobacterium gordonae. Antifungal and antibacterial treatment was launched. Because of opportunistic infections, lymphocyte levels were assessed and CD4 T lymphocyte level was detected as 68. Therefore intravenous immunoglobulin treatment was started. Patient was not responded to treatment and died. After excluding other causes of immune deficiencies, it was thought that seconder immunodeficiency emerged due to long time glucocorticoid use.

Discussion: The use of glucocorticoids affects the immunological system both at the cellular and humoral level. T cells are effected more than B cells. Naïve CD4+ T cells primarily effected. Common viral, bacterial and fungal (mainly Candida species) pathogens are encountered with greater frequency in a dose dependent manner during therapy with glucocorticoids and many patients die because of these infections. Older patients are at higher risk for infection and with the addition of glucocorticoid usage, the infection risk is greater. In our case, glucocorticoid usage developed secondary immunodeficiency and patient died because of opportunistic infections Hence, we want to emphasize immunodeficiency and the risk of atypical opportunistic infections due to glucocorticoid usage.

Keywords: immunodeficiency , glucocorticoid , elderly

CP-05

WEIGHT LOSS IN THE ELDERLY

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Objective: The differential diagnosis of unintended weight loss in the elderly can be extensive. The most commonly identified causes are summarized with the mnemonic "Meals on Wheels". We reported the case of seventy years old women who presented unintentional weight loss in relation to literature.

Case: A 70-years-old women with 5 kg unintentional weight loss within one year was assessed. She had no history of tobacco or alcohol use, no history of malignancy. Measurement of weight was 50 kg and body mass index (BMI) was 19,5 kg/m^2. The patient did not suffer from nausea, vomiting, night sweats, rashes, lumps, skin lesions or changes in bowel or urinary habits, and had not noticed any blood in her stool. However, she became tired during the day. And also, her normal activities, such as supermarket shopping, were described as 'exhausting'. On examination, there were no goiter, lymphadenopathy, or signs of septicemia. Full blood count, serum electrolytes, creatinine phosphokinase, thyroid function tests and liver biochemistry were in normal levels. She denied any recent infections and chest pain. Computerized tomography (CT) (thoracic and abdomen) and mammography showed no pathologic finding. She was living alone, and she told eating meal was 'not exciting'.

Results: Patients may benefit from simply being offered frequent, small servings of foods that they like, and eating with other people or family makes eating interesting. So we suggested small frequent servings, suggested her family that they should visit the old lady for

evening meals. We wanted the old lady to make her own shopping, and we added 600 kcal to daily energy requirement for weight gain. The total energy requirement for weight gain was found to be 2001 kcal. After 4 months, she gained weight and she was more active.

Conclusion: The findings of the history and physical examination guide the initial diagnostic assessment. Along with the nutritional suggestions, when possible, physical exercise should be encouraged, because increased activity has been shown to promote appetite and food intake. If the patient's food intake is inadequate; nutrient density of food should be increased. If weight does not improve, daytime snacks between meals can be offered. It was shown that oral nutritional supplements could improve nutritional status for undernourished elderly patients. In this case, we wanted to emphasize the importance of the nutritional status of an old lady.

Keywords: Elderly, involuntary weight loss

CP-06

IMPORTANCE OF PHYSICIAN'S TOUCH; LIMITED VALUE OF LABORATORY TESTS ALONE?

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Intraduction: The physical examination remains the cornerstone of the patients evalution. Failure to perform a physical examination, may be a significant source of medical error, leading to missed or delayed diagnoses. Many renal masses remain asymptomatic until the late stages of the disease. When Renal cell carcinoma (RCC) is symptomatic, it's often advanced and prognosis is poor. Physical examination has a limited role in RCC diagnosis. However, the findings like as (%25) Palpable abdominal mass, should prompt radiological examinations. We wanted to draw attention to the significance of physical examination in asymptomatic RCC with this case. We present a patient who an incidentally discovered abdominal mass during routine physical examination.

Case: A 68 years old men presented to the geriatric clinic for a routine health control. He had no complaints in arrival. He had been smoking since he was 20 years old. He was diagnosed with hypertension 6 months ago but was not taking regular medication. Blood pressure (right arm 200/100 mmHg left arm 210/100 mmHg) heart rate: 78 / min BMİ (body mass index): 29.4 was measured. On physical examination, the mass sized 8 cm was palpable in the right subcostal area. On auscultation, there were bibasilar crepitant rales. Biochemical parameters were requested considering the age and risk factors of the patient. Laboratory evaluations, including urinalysis, were within normal limits, except for glukose:147 mg / dL , HbA1c: 6.6%, LDL: 164 mg / dL. Chest x-ray was planned to patient because of crepitant rales. Then lung tomography for multiple 0.5 cm nodules seen on chest X-ray and abdominal ultrasonography for abdominal mass were requested. A cortical mass of 6 cm was spotted in the abdominal legion which coinsidentally included in the lung tomography. Said mass was a solid hypervaskuler of 6.5x3 on the the right kidney which pointed towards RCC. Radical nephrectomy was planned.

Discussion: Most patients hope for more face-to-face time with their physicians, but most physicians want to ensure rapidly that a diagnosis, treatment plan and the expected benefits or adverse effects of treatment are well understood by the patient. Many physicians are concerned that the physical examination has been progressively deemphasized in favor of laboratoary test and imaging that are easy to obtain and record in electronic health records.

The 5-year survival rates of incidentally detected asymptomatic RCC cases are significantly higher than symptomatic RCC cases. Therefore early diagnosis is rather important. Anemia, polycythemia, hematuria can be seen in laboratory tests at asymptomatic RCC. But in our patient, although the mass was 6 cm, there were no abnormalities at the laboratory. We show that this case to the physical examination of its "utility" beyond that of reaching a diagnosis can be beneficial to both doctor and patient.

Keywords: physical examination , Renal cell carcinoma , elderly

CP-07

RARE HYPOCALCEMY THAT CAUSED BY COLON ADENOCA

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Introduction: When resistance hypocalcemy caused cancer calsitonine level has become an important level. Thyroid meduller cancer comes concentrated in the height level of calciton. An interesting case is followed below.

Case: 80 year old female patient was adimmited in to hospital who had lots of general weakless and edema in her body. The patient had an tiroidectomy operation 20 years ago. In patient examination hct: 25% hb: 7.5 g/dL AST 240 U/L , ALT 210 U/L, GGT 310 U/L, INR: 1.96, albumin 1.9, proBNP: 9880 pg/mL, ionise calcium: 2.90 mg/dL,procalsitonin of 16.7ng/mL, chest and abdominal CT: pleuvral effusion, pericardial effusion and has available. In the patient treatment has begun diuretic .There weren't any eproductive in the blood and urine cultures. Despite the heavy antibiotics in the patient treatment procalsitonin levels was 13-16ng/dL. IT'S taken in the 1880's to the level of calcitonin and the patient was detected. Colonoscopy and gastroscopy were performed. Sigmoid polyps detected and 2 or 3 inch polypectomy was performed. Adenocarcinoma in her pathology. For the patient PET–CT was taken. Around the sigmoid colon involvement was detected. The patient was transferred to surgical service.

Conclusion: if hypocalcemia is accompanied by high levels of calcitonin culture without upper level of procalcitonin in our case will be tested . As it is rare, the calcitonin-secreting colon TM can be detected.

Keywords: calcitonin, colon cancer, procalcitonin,

CP-08

A CASE OF HYPERPARATHYROIDISM SECONDARY TO 25(OH)D VITAMIN DEFICIENCY – TO EMPHASİZE IN THE ELDERLY

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Objective: Even though Turkey is a sunny country, vitamin D deficiency/insufficiency is not rare, especially in the elderly. Vitamin D defieciency/insufficiency results with malabsorbtion of calcium, secondary hyperparathyroidism, and eventually osteoporosis and osteomalacia. Hyperparathyroidism may be overlooked in the elderly. So we aimed to emphasize the importance of diagnosis and therapy of vitamin D deficiency in the elderly with a case.

Case: 71 years old lady came to outpatient clinic of geriatrics with the lomber and whole body pain, myalgia and pruritis. She had diabetes mellitus, hypertansion, hyperlipidemia. She had total gastrectomy operation because of gastric malignity. In her physical examination,; blood pressure was 140/70 mmHg, HR: 75 / min, no pathological finding except for the operation scar in the abdomen was

detected. Biochemical measurements were as follows: Serum blood glucose: 98 mg / dL, post prandial glucose: 162 mg / dL, all the other ALT, AST, Urea, creatinine, sodium, potassium, calcium, phosphorus, CPK, sedimentation rate, CRP, Hemogram, thyroid function tests, Vitamin B12, folate values were normal. ALP level (308 U / L) and PTH level (268 pg / mL) were high, and 25 OH Vitamin D level was low (3 nmol / L). Osteoporosis was detected in the bone zone densitometer (total T score: -2.51) and in the femur (Total T score: -2.64). Statins and oral antidiabetics were stopped. Because the patient had a gasterectomia, Vitamin D3 300,000 IU IM and orally 300 mg Calcium carbonate plus Calcium lactate gluconate 2940 mg (equivalent to 500 mg total ionized calcium) were prescribed at 4 weeks intervals. After 3 months of follow-up, ALP level was 138 U / L, PTH level was 193 pg / mL, and 25 OH Vitamin D level was 50 nmol / L, Ca level was normal. Vitamin D; 150,000 IU per month was recommended for the patient as continuing treatment.

Results: In this case, there were symptomatic manifestations of significant Vitamin D deficiency, and after the treeeatment; laboratory and clinical improvement was observed. Bone densitometry was planned to be checked after 3 months and 1 year after the first.

Conclusion: In case of hyperparathyroidism, Vitamin D deficiency should be considered, especially in the elderly. This case suggests that gastrectomy should be remembered as an aggravating factor for vitamin D deficiency. People with bone disease, musculoskeletal symptoms suggestive of vitamin D deficiency, those with risk factors for vitamin D deficiency and inadequacy (such as dark skinned people, elderly, obese, malabsorbtion, glycocorticoid drug users) should be examined for vitamin D. We aimed to emphasize once more the importance of diagnosis and treatment of Vitamin D deficiency through a case in our study.

Keywords: hyperparathyroidism, 25(OH) D vitamin deficiency, elderly

CP-09

BOUVERET SYNDROME: A RARE CAUSE OF INTESTINAL OBSTRUCTION

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Introduction: Bouveret syndrome is the migration of a gallstone to the duodenum via a cholecystoduodenal or cholecystocholedochal fistula. The early diagnosis and treatment of Bouveret syndrome are necessary to reduce morbidity and mortality. Here we report the case of an 84-year-old female in order to bring attention to this rare condition.

Case: An 84-year-old female patient presented nausea, abdominal pain. On physical examination, there was widespread abdominal distention. She was admitted to the general surgery department with a prediagnosis of acute abdomen.

Laboratory tests done at admission revealed, leukocyte count of $7.9x10^3$,C-reactive protein level of 16.2 mg/dL. On abdominal tomography, extensive distention and multiple air-fluid levels were noted in the bowel segments, especially the small bowel, and an opacity of about 27 mm in size was observed in the intestinal segments in the right lower quadrant of the abdomen.The patient underwent emergency surgery for intestinal obstruction. On laparotomy, a stone was found obstructing the entire lumen 5 cm from the terminal ileum and was removed by enterotomy. A fistula was observed between the fundus of the gallbladder and approximately 2 cm distal of the pylorus. A stone was removed from the fundus of the gallbladder. On postoperative day 10, the patient was discharged.

Discussion: Bouveret syndrome patients exhibit non-specific symptoms. Risk factors for Bouveret syndrome include age over 70 years, female sex, gallstones larger than 2.5 cm, and history of gastrointestinal system surgery. Bilioenteric fistulae are a serious complication of chronic gallbladder disease. The gallbladder may frequently fistulize to organs like the duodenum, stomach, and colon.

Although clinical diagnosis of Bouveret syndrome is difficult due to its rarity a preoperative diagnosis is possible in most patients with current radiologic imaging and endoscopic examination. Enlarged small bowel loops, infra biliary gas, and ectopic gallstone on plain abdominal radiograph is referred to as Rigler's triad. However, gallstones may not be visible on direct radiograph because they contain only 10-15% calcium. Ultrasonography may facilitate the diagnosis of a fistula or impacted gallstone as well as reveal residual cholelithiasis or choledocholithiasis. Computed tomography may reveal stones within the intestinal lumen, intestinal obstruction, pneumobilia, and sometimes bilioenteric fistula. Intestinal system defects following laparoscopic or open cholecystectomy are repaired primarily. In patients who cannot undergo cholecystectomy, stones should be moved from the gallbladder to the stomach or small intestine using a milking action in order to prevent recurrences.

In summary, Bouveret syndrome is a rare clinical condition; however, there is no consensus regarding an approach to treatment. The treatment approach should be determined on a case-by-case basis.

Keywords: Bouveret syndrome; obstruction

CP-10

PROSTATIC ABSCESS AND TRUS GUIDED TRANSRECTAL DRAINAGE TREATMENT

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A 72-year- old male patient was admitted to our clinic with infravesical obstruction symptoms like nocturia, dysuria, in addition to fewer, sweating, general poor health, and constipation and pain in perineum. Previously, he had already been to four medical centers where he was given antibiotherapy upon diagnosis of urinary system infection and acute prostatitis. After temporary recovery, all the symptoms returned back. Patient had had 18.000 leucocytosis which was reduced to 14.000 leucocytosis with the antibiotherapy which again increased afterwards.

On general examination he had general poor health, fever, sweating and tachycardia. On rectal examination he had pain, but there was no other sign. Because of constipation and pain in the perineum, we asked gastroenterology consultation. On rectoscopy that was performed by the gastroenterologist, a fluctuation which belonged to a possible prostatic abscess was seen. The diagnosis of prostatic abscess was confirmed by transrectal ultrasonography and pelvic magnetic resonance. It was 5.5 cm in diameter.

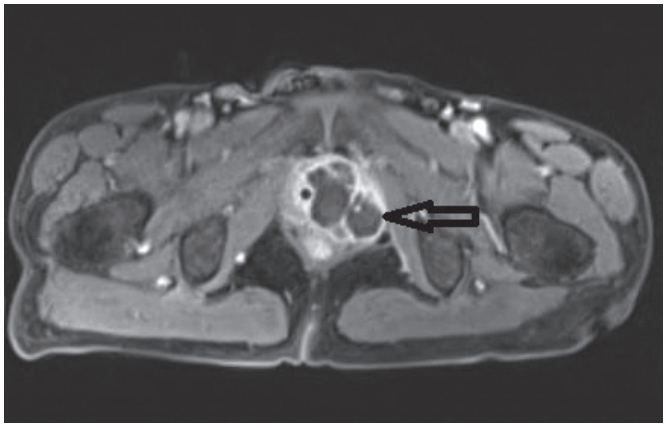
Because the abscess originated from the peripheral zone and widened towards outside the prostate we disregarded transurethral way for the treatment. In our center we decided to drain the abscess from the transrectal way by the interventional radiology department. After the prostatic abscess drainage, the general condition of the patient improved. One day later, it was seen that the level of leucocytosis decreased to 11.000. Pathological examination of the abscess material revealed no malignant cells.

But a week later the abscess relapsed and all the symptoms occurred again. So we decided to give the same treatment, adding placement of a 8F drainage tube by the perineal way. At the end of almost six days during which purulent matter was drained with drain-

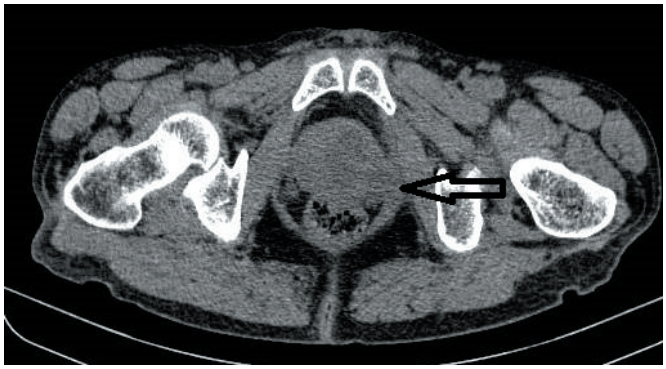
age tube, all the symptoms of the patient disappeared and abscess did not relapse again.

Prostatic abscess constitutes 0.5% of all prostate diseases. This illness is seen in elderly patients with low body resistance living in bad hygienic conditions. Presence of voiding disorders in these patient suggests the benign prostatic enlargement whereas presence of infection symptoms suggests the acute prostatitis. Treatment is based on these two diagnoses. But if the patient is old, has bad general condition, and resistant to treatment we must consider the possibility of prostatic abscess. If there are no findings of the prostate abscess in digital rectal examination of these patients, pelvic MR, lower abdominal computerized tomography or transrectal ultrasonography are essential radiologic examinations to make diagnosis of prostatic abscess.

Keywords: Prostatic abscess, abscess drainage, prostate, acute prostatitis



Picture 1. Prostatic abscess on T1 axial MR with contrast.



Picture 2. After the therapy the appearence of the prostate on BT without contrast.

CP-11

BILATERAL SWELLING OF THE HANDS IN AN ELDERLY GENTLEMAN

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Background: Remitting seronegative symmetrical synovitis with pitting oedema (RS3PE) syndrome which mostly occurs in the elderly people is characterized by acute onset distal symmetrical synovitis with pitting oedema over the affected joints, especially the dorsum of the hands. Most of RS3PE cases are idiopathic but some are secondary to autoimmune disease, malignancy or neurodegenerative disorders. It shows a benign clinical course because of the good response to low dose steroid treatment.

Case presentation: The patient was a 85 year old man with no remarkable past medical history except prostatectomy for benign prostate hyperplasia presented with sudden onset bilateral swelling of the hands accompanied by morning stiffness lasting about half an hour, impaired grip function. The patient had no other constitutional symptoms. He denies any history of trauma, rash, fever and his medication history was negative. The physical examination revealed painful pitting oedema of the dorsum of both hands causing limitation of movement and function, moderate tenderness of the metacarpophalangeal, proximal and distal interphalangeal joints. His vitals were within normal limits and in rest systemic examination(including locomotor), no abnormality was detected. Laboratory data showed an erythrocyte sedimentation rate(ESR) 22mm/h and a slightly increased C-reactive protein(Crp) 1.16 mg/dL. The haematological values and biochemical markers were found to be normal except for haemoglobin (11.9 g/dL) which is consistent with iron deficiency anemia. Rheumatoid factor (RF), anticitruline (anti-CCP), anti-nuclear antibody(A-NA), ENA, anti-ds DNA antibody, hepatitis B and C antibodies were negative. Serum prostate-specific antigen (PSA) level was normal. Radiological examination of the hands showed soft tissue swelling and did not reveal any erosions. Ultrasonography of the hands revealed extensor tenosynovitis. Endoscopy of upper gastrointestinal system and colonoscopy were normal. The diagnosis of unilateral RS3PE was made. Considering the possibility of an underlying malignancy, CT scan of the thorax and abdomen was performed and displayed nothing. The patient was treated with 15 mg prednisolone and he responded as pain starts subsiding within a week and all symptoms were relieved within four weeks.

Conclusion: This case demonstrates this rare clinical entity RS3PE and highlights the necessity of awareness to clinicians.

Keywords: RS3PE, elderly, swollen hands

CP-12

INFLUENZA A VIRUS INFECTION TRIGGERING MYOCARDIAL INFARCTION AND ACUTE HEART FAILURE

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Introduction: Influenza infection can lead to serious complications in people having underlying medical disorders such as cardiovascular diseases. It is known that Influenza viruses have direct effect on the myocardium and can also lead to exacerbations of existing cardiovascular diseases. Geriatric patients are at high risk of morbidity and mortality during an Influenza infection.

Case presentation: An 85-year-old woman was admitted to the hospital with fever, chest pain and shortness of breath present for 2 days. Her past medical history included coronary artery disease, aortic valve stenosis, hypertension, hyperlipidemia and hypothyroidism. She underwent a coronary artery by-pass and a bioprosthetic valve replacement operation 4 years ago. Her physical examination revealed tachypnea with breaths 34/minute. Respiratory sounds were compatible with paninspiratory rales blaterally at lower and mid regions. At room air her O2 saturation rate was 85%. Cardiovascular assessment showed jugular venous distention, a S4 gallop rhythm, an apical 3/6 pansystolic murmur, an aortic 2/6 systolic ejection murmur. Her blood pressure was to be 158/60 mmHg, heart rate was 112 beats/min. Pretibial edema was observed. Her chest X-ray showed

bilateral pulmonary vascular cephalization, infiltrates suggesting alveolar edema. ECG revealed pathological Q-waves on the inferior derivations, a 1-mm- ST depression on the precordial leads V4,V5 and V6. Echocardiography revealed a decrease in her left ventricular ejection fraction rate of 40% (N: >55%) which was known to be 55-60% on her previous Echocardiography. Basal inferolateral wall was akinetic as before but severe basal and mid anterolateral motion hypokinesia were new findings. The mitral valvular structure was normal, but severe functional mitral regurgitation was seen. The bioprosthetic aortic valve was functioning normally. Her first laboratory results showed a Troponin I as 3.066ng/mL (N:<0.04);NT Pro BNP 7340 pg/mL (N:<738). A rapid Influenza testing resulted positive for Influenza A. With these findings the patient was admitted to the Intensive care unit with the diagoses of acute coronary syndrome and acute heart failure, developed during an influenza infection. Mechanical ventilation was performed and she was given acetylsalycylic acid, ticagralor, nitroglycerin and furosemide infusion. Enoxaparin was started after her INR level dropped below 2.0. Influenza infection was treated with oseltamivir for 5 days. Her previous angiography was re-assessed;many lesions which were not amenable to revascularization and supplying the newly diagnosed hypokinetic regions were determined. A new angiography was not performed, with the decision of continuing medical therapy.

Discussion: This case is a good example of increased risk for cardiovascular mortality and morbidity during influenza infections and emphasizes the role of Influenza vaccination in vulnerable patients such as those with coronary artery disease.

Keywords: Acute myocardial infarction, Acute heart failure, Influenza infection

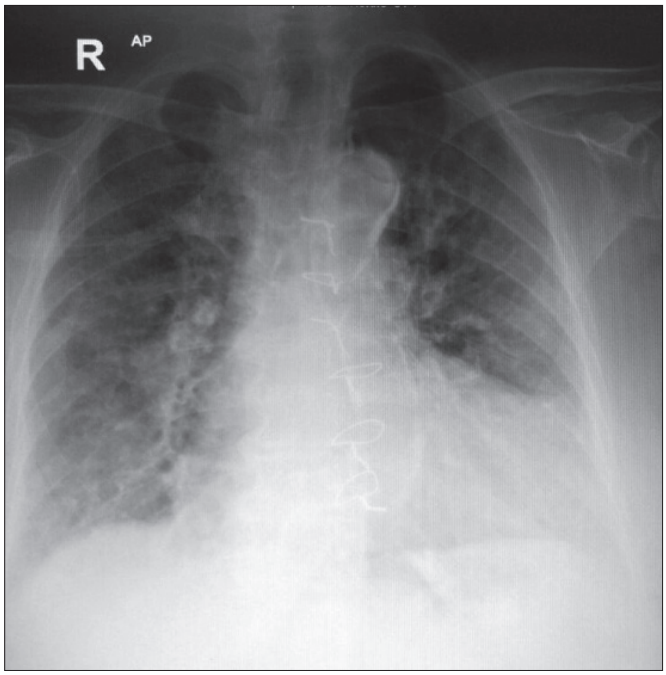

Figure 1.

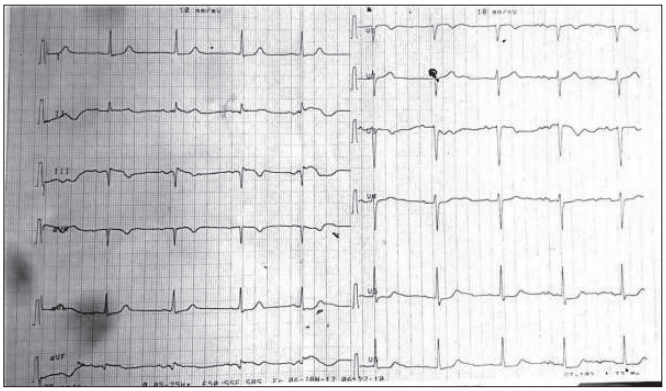

Figure 2.

CP-13

AN ALTERNATIVE TREATMENT FOR RESTLESS LEG SYNDROME: NEURAL THERAPY - A CASE REPORT

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Objective: Restless legs syndrome (RLS) is a neurological disorder characterized by disturbing motor and sensory symptoms, especially on the limbs. The need to move the extremities and parestheses are the major symptoms which increase at night and rest, decrease with activity. Neural therapy (NT) is a regulatory therapy using local anesthetic agents. Here, we will present a geriatric patient with a diagnosis of RLS treated with NT.

Case: Z.G. 71-year-old female has HBS symptoms for 5-6 years. Medical treatment (pramipexole) had not benefited. The symptom severity assessed by the visual analogue scale (VAS) (0-10) was 8. There were histories of lumbar disc herniation and cesarean operations. Complete blood count, routine biochemistry (including iron and other electrolytes), ferritin, vitamin B12, folic acid, thyroid function tests, vitamin D levels were normal. On physical examination C2 and C3 had tenderness at Adler-Langer points. There was blockage in the junction of thoracolumbar region during Kipler test. In applied kinesiology test, scars of cesarean and lumbar operations were found as disturbing field. In the treatment of the patient, lidocaine diluted with 0.4% saline was used. Treatment was done once a week. In the first treatment session quaddel injection was applied locally to the painful and sensitive areas on legs and segmental quaddel application was done between the thoracal 9-sacral 1 vertebral segments. In the second treatment session, disturbing field therapy was performed with addition to the first treatment session. Subcutaneous application was made for the belly, vaccine scars and surgical scars. In the third, fourth, fifth and sixth sessions, the lower extremity circulation protocol was applied in addition to the application of local, segmental, and disturbing field therapies. In the seventh session patient's VAS value declined to 3. The patient was called to control after three weeks.

Conclusion: NT may be an alternative treatment that can be performed in the treatment of RLS.

Keywords: Injection, neural therapy, restless leg syndrome

CP-14

PHENYTOIN INDUCED DRESS SYNDROME

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Background: Drug Rash with Eosinophilia and Systemic Symptoms (DRESS) syndrome reflects a serious hypersensitivity reaction to drugs, characterized by skin rash, fever, lymph node enlargement, and internal organ involvement. Drugs most often implicated in DRESS are anti-convulsants, allopurinol, sulfonamides and sulfasalazine. Delayed onset of symptoms (2-6 weeks following culprit drug use) is an important feature of DRESS. The main treatments of DRESS are withdrawal of culprit drug and corticosteroid treatment.

Case presentation: We describe the case of a 83 year old woman with a history of hypertension who presented to our outpatient clinic. About one month prior to admission she was hospitalized because of subdural hematoma after falling from stairs. Phenytoin was started in hospital and she continued to use after discharge. After three weeks of treatment she complained of nausea, vomiting and fever. She was admitted to emergency department and hyponatremia was detected. Her hyponatremia was resolved and phenytoin had been replaced with levetiracetam due to hepatic transaminase elevation at discharge. Subsequently the patient had complained of widespread erythematous rash on the trunk. Due to rapid worsening of the cutaneous rash and itching she was admitted to our outpatient clinic. On admission her vitals were within normal limits except fever. Physical examination revealed generalized erythematous maculopapular desquamative skin eruption on the trunk accompanied by pruritus. With the exception of axillary and inguinal lympadenopathy no other significant physical findings were present. Laboratory investigations revealed elevation of transaminases, *gamma-glutamyl transferase* (*GGT*), alkaline phosphatase (ALP), lactic dehydrogenase (LDH), C-reactive protein and eosinophilia. On her peripheral blood smear eosinophilia was noted without atypical lymphocytosis. Abdominal ultrasonography was normal. Collectively, laboratory results accompanied with the clinical findings of fever, systemic erythematous rash, hypertransaminasemia, lymphadenopathy, and the recent ingestion of phenytoin the diagnosis of DRESS was made. Peroral steroid treatment was started, afterwards hepatic transminases levels became normalized and complete resolution of all symptoms was achieved.

Conclusion: DRESS syndrome is a serious drug reaction that can cause mortality due to systemic involvement so early diagnosis is essential.This syndrome should be kept in mind in patients taking drugs that are related to DRESS.

Keywords: Phenytoin, DRESS, Older people, Drug reaction

CP-15

A GRANDMOM WHO TAKES CARE GRANDCHILD AND HAS COUGH,FATIGUE AND LEFT ARM PAIN

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Introduction: Sometimes old people don't want to complain about their problems or they may tend to underestimate them. Especially if they have a functional role in the family, this tendency may be more pronounced.

Case: 71 years old female, was admitted to emergency department with cough and fatigue for 4 days. Beside that, she told that she takes care her 1 year grandchild and because she carries the kid from time to time, she felt pain in her left arm and shoulder. She said her left arm movements were painful.In these 4 days, she started to amoklavin-klavulonat and pseudoephedrine for her flu like symptoms,without consultation a phsycian.There was no any chest pain, back pain or dispne. In her story there was no any comorbidities and chronic medicine use. In her examination, there was crepitant rales in basal area of right lung, blood pressure was 168/90 mmHg ,heart rate:103/Rhytmic and temperature was 36.0 degrees. Because of her age, fatigue and arm symptoms, ECG was taken and ECG changes was seen.Sub acute Inferolateral Myocardial Infection was diagnosed, she was taken to coronary intensive care unit, after she was hospitalized laboratory results arrived to emergency department. CK-MB was 57 (normal range<25) , Troponin I:2.46 (normal range<0.05), CRP :175 (Normal Range<5).

Discussion: this case give important hint for evaluation of an elderly person. If they have an important and/or functional role in the family, they didn't want to leave from this situation. So they can tend underestimate their complaints or problems. (she wanted to think about her left arm pain as an orthopedic problem) In her story, she had no any cardiovascular problem, but it's not a rule for a new event. She used pseudoephedrine for 4 days without any doctor advise. This may lead the cardiovascular problem.And the last thing to say; especially in a geriatric patient; chest or back pain or dyspnea is not always a rule for a cardiac event. In evaluation of a geriatric patient we must be more carefull because there may be no any serious complaint or symptom for a serious disorder.

Keywords: underestimate,myocardial infarction, caregiving

CP-16

A FALL IN THE ELDERLY WITH ATYPİCAL SYMPTOMS AND A RARE CAUSE

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Objective: Falls are one of the most important geriatric syndromes. Falls are associated with higher morbidity and mortality. Immobilization because of a fall may lead to serious complications. The most frequent causes of falls are environmental factors, gait and balance disorders, muscle and coordination problems. However, rare causes sometimes may be unnoticed. In this case, we aimed to take attention to a seldom reason of falls-acute infection.

Case: 88 years old lady was admitted to emergency service because of a fall. She told that she did not feel well before the day of fall. But she did not have vertigo, fever, or pain. At the moment of falling there was no environmental factor, vertigo, syncope or tachycardia symptoms. She had only weakness. She said she felt weak and fell down. At the emergency department, her vital findings were normal. She did not have fever, cough, hypotension or arrhythmia. In physical examination, there were fine rales bilaterally. There was no other physical examination finding. In terms of biochemical parameters, there was only increase in CRP value (10 mg/dL), there was no leukocytosis. In the PA lung X-ray right sinus was closed. She was hospitalized with a suspect of pneumonia. After she was hospitalized in the first 8 hours, her fever increased to 38.2, leukocyte count increased to 13.000 10*3/μL, CRP was 12 mg/dL, P02 was low. Her blood cultures were taken and antibiotic treatment was started empirically; IV clarithromycin 500 mg 2*1 and piperacillin/tazobactam 3*2,25 gr**.** Blood culture and sputum cultures were negative. The empirical antibiotic treatment was continued for 3 weeks. Her fever, symptoms were controlled, lung X- ray got better. She was discharged with recovery.

Results: In this case, there was pneumonia in our patient, but there was only weakness when she fell down. And at the emergency department, only CRP was high and there were minimal respiratory findings. After the patient was hospitalized in the first 8 hours the clinical findings were more apparent.

Conclusion: In this case of fall, we saw that acute infectious reasons also may lead to falls where the findings were atypic, obscure and insignificant. Physicians treating elderly people should be aware of atypical presentations in the elderly and practice comprehensive approach in the diagnosis, treatment, and follow-up of problems in the elderly population.

Keywords: fall, atypical, elderly, geriatric syndrome

CP-17

INFLUENZA A - RELATED ACUTE MYOCARDIAL INFARCTION IN AN ELDERLY WITH NO PREVIOUS HISTORY OF CORONARY HEART DISEASE

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Introduction: Influenza infection can lead to complications in patients having underlying cardiovascular diseases. There is increasing evidence from studies that Influenza infection is associated with acute myocardial infarction and in patients with known coronary disease Influenza infection can trigger ischemia. Here we present a patient admitted to the hospital with Influenza A infection who had an ischeamic heart attack but did not have a previous history of coronary heart disease.

Case presentation :A 72-year-old woman was admitted to the hospital with fever, headache and dry cough present for 2 days. Her past medical history included hypertension and hyperthyroidism. Her physical examination findings were as fever to be 38.9 °C, blood pressure 140/80 mmHg., a pharyngeal erythema and rare rhonchi were heard by auscultation. Cardiac sounds were normal with a normal sinus rhythm. The laboratory findings on admission were as leukocyte count 5790 with 77.7% neutrophils, hemoglobin 11.4 g/dl and platelets as 154.000 . Her renal and liver function tests were within the normal range. Influenza antigen testing was reported to be Influenza A positive. No bacterial growth was detected in the blood cultures at the end of 7 days.. Her chest X-ray on admission showed no pulmonary infiltrates. She was diagnosed to have Influenza A and was started to receive oseltamivir antiviral treatment. On her second day of admission during the night she described chest pain, breathing difficulty, numbness over the fingers and a feeling as if falling down. Her blood pressure was measured as 164/90 mmHg and ECG showed a sinus rhythm but nonspecific V1-V3 t-wave changes. Blood testing for troponin I was found to be 0.133 ng/ml . The troponin I was found to be 0.103 ng/dl 6 hours later and normal on the next morning. Her Echocardiography was performed and left ventricular systolic function was found to be normal with EF as 60%, mild mitral and tricuspid valve failure, and mild pulmonary hypertension. She was diagnosed to have non-ST elevation myocardial infarction and was started losartan, enoxaparin, coraspirin, metoprolol, clopidogrel. Her chest pain did not occur again under this treatment. Her antiviral treatment was continued for 5 days and was discharged to have to undergo coronary angiography. She was also advised to receive yearly Influenza vaccinations which she did not have done this Influenza season.

Conclusion: Influenza infection can induce ischemic heart attacks although not diagnosed before. Yearly influenza vaccinations in elderly, especially those having cardiovascular diseases, should be done prevent infection which might later be a trigger an ischemic heart attack.

Keywords: Influenza A infection, Acute myocardial infarction

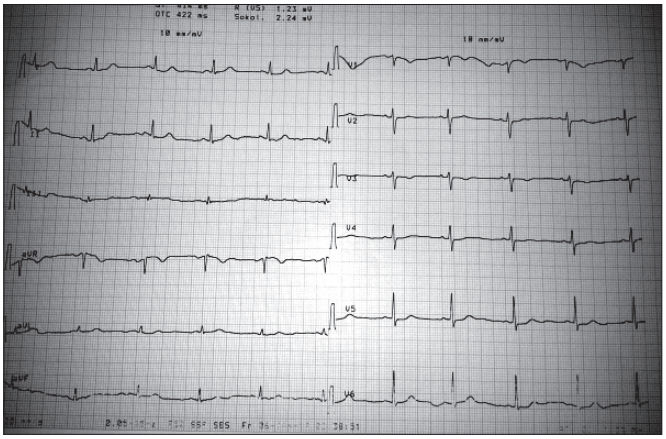

Figure 1.

CP-18

THE IMPORTANCE OF CARE AND REHABILITATION IN A PATIENT WITH LEFT HEMIPLEGIA DUE TO HEMORRHAGIC MCA ANEURYSM; CASE REPORT

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Hemiplegia after cerebral aneurysm hemorrhage is one of the most important causes of disability in adults. In hemiplegia rehabilitation, the objective is to increase the functional capacity and enable psychosocial restoration.

Case: A 71-year-old female patient who 2.5 years ago underwent cranial surgery due to middle cerebral artery aneurysm bleeding and was followed up with GKS score 8 in intensive care unit for 1 month was admitted to our care center with left hemiplegia and nearly right hemiplegic hemiparesis . In the first examination performed at our center, the patient was conscious but had no cooperation or orientation, bilateral upper and lower extremity muscle strength was 1/5. The patient had tracheostomy tube, PEG tube and urinary catheterization. She was started rehabilitation program immidiately. We performed passive ROM exercises, cervical mobilizations, respiratory rehabilitations, diaphragm mobilizations, percussion, vibration and aspiration, assisted seating and head control exercises at the bedside, sensory exercises (massage to palmar and dorsal sides of hands and feet with therapy balls , tongue / cheek and palate stimulation with an automatic toothbrush), standing with assistance of tilt-table exercises and a step-up exercises (by foot lifting). NMES therapy to stimulate the atrophic muscles.

After 24 weeks of intensive physical therapy process, the patient started to become cooperative and oriented. Cold packs and compex device were used. We started to use braces to her joint and muscle contractures. By increasing lung capacity with respiratory exercises decannulation was performed to her tracheostomy. By making frequent changes in position we prevented pressure ulcers. By closely monitoring the patient we prevented serious infections. Botulinum Toxin A injection was applied to the left gastrocnemius muscle, left semi-tendinosus muscle, and left hand flexor digitorium profundus muscle. The right side muscle strength of the patient is now 5/5 and the left side muscle stregnth is 3 + / 5. All extremities are in neutral

position now and only left ankle flexion and hip flexion are limited. Left hand second finger interphalangial joint has flexion spasticity and the last sensation of the joint is soft and can be made neutral manually (easily). She has no any swallowing deficit for 6 months. Peg tube is going to be extracted.Our goal is to make her as independent as possible in daily life activities and to walk with little support.

Bleeding aneurysms have a high mortality rate and result in serious neurological deficits in most of the cases. With a multi-disciplinary approach, the general medical condition of the patient can be stabilized, the complications can be reduced. By the help of intensive and comprehensive rehabilitation program most of the functional losses reduce as well as the economic losses decrease while the patient's quality of life increases.

Keywords: Hemiplegia, Cerebral Aneurysm, Rehabilitation

CP-19

AN IMPORTANT CAUSE OF TETRAPLEGIA IN A GERIATRIC PATIENT: CERVICAL SPONDYLOTIC MYELOPATHY - CASE REPORT

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Objective: Cervical spondylotic myelopathy (CSM) is one of the most severe complications of cervical spondylosis. Clinical manifestations usually begin insidiously but can also cause sudden neurological loss. It is most commonly seen acquired spastic tetraplegia in late times of life. In this case report, a case of CSM causing spastic tetraplegia in a geriatric male patient will be presented.

Case: S.E. A 71-year-old male patient was admitted to the emergency room with a complaint of not being able to grow up and walk. Vital findings were evaluated as normal. Awareness of consciousness, speech disturbance, pain and urinary incontinence were not detected. Physical therapy and rehabilitation clinic consultation was requested. The upper and lower extremity range of joint movements were normal. Muscle strength in the upper and lower extremities was proximally and distally 2/5. He could not stand and walk. There was no swallowing difficulty and speech disorder. On the cervical vertebral magnetic resonance imaging (MRI) of the patient, degeneration in the vertebral discs, multiple disc protrusion between C2-C3 and C7-T1 levels, cord compression and spinal stenosis were detected (Figure-1). The patient was urgently operated by the neurosurgeon for these acute symptoms of CSM. Total laminectomy was performed on the C3-4-5-6 vertebrae with posterior approach and that C4-5-6 was stabilized with 6 lateral mass screw-rod systems (Figure-2). Patient was discharged from the Neurosurgery department and accepted for rehabilitation program to Physical Medicine and Rehabilitaton department. His neurological level at admission was determined as C4 ASIA D according to the American Spinal Cord Injury Association classification system. According to the Functional Ambulatory Scale (FAS), the patient was at stage 0 non-functional ambulatory level. The patient's rehabilitation program began as passive range of motion exercises for joints, active assistive or active exercises on appropriate muscles, strengthening exercises, stretching exercises, breathing exercises and cervical isometric strengthening exercises in collar. The patient was taken to the verticalization program with tilt table. After completing the verticalization program the patient was lifted to the parallel bar. Balance exercises, posture exercises, standing and walking training were given. After the rehabilitation program, the patient's neurological level remained unchanged, rated as C4 ASIA D, but there was an increase in muscle strength. The patient was discharged at the level of ambulation at home (FAS 3) under the guidance of one person with a fixed walker.

Conclusion: CSM is an important cause of tetraplegia. The aim of the surgical treatment is to stop the progression of myelopathy by removing the pressure. Conservative treatment methods may increase the success rate in clinical follow-up.

Keywords: Cervical spondylotic myelopathy, tetraplegia, rehabilitation

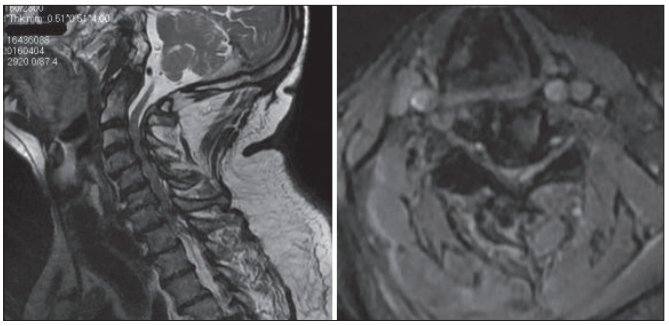

Figure 1.

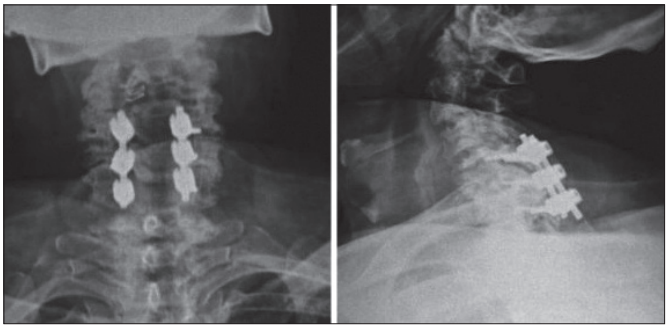

Figure 2.

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