RFP Journal of
Gerontology and Geriatric Nursing

Corresponding address
Red Flower Publication Pvt. Ltd. 48/41-42 DSIDC, Pocket-II, Mayur Vihar Phase-I Delhi - 110 091(India)
Phone: 91-11-22754205/45796900, Fax: 91-11-22754205
E-mail: redflowerppl@gmail.com
Web:www.rfppl.co.in

RFP Journal of Gerontology and Geriatric Nursing (JGGN) is a tri-annual peer-reviewed journal publishing latest developments in the management of acute and chronic disorders and provide practical advice on care of older adults across the long term continuum. The **Journal of Gerontology and Geriatric Nursing** is publishing clinically relevant articles on the practice of gerontological nursing across the continuum of care in a variety of health care settings.

Subscription Information

India

Institutional (1 year): Rs.5500

Rest of the World

Insitutional (1 year) USD 430

Payment methods

Bank draft / cashier & order / check / cheque / demand draft / money order should be in the name of **Red Flower Publication Pvt. Ltd.** payable at **Delhi**.

International Bank transfer / bank wire / electronic funds transfer / money remittance / money wire / telegraphic transfer / telex

1. **Complete Bank Account No.** 604320110000467
2. **Beneficiary Name (As per Bank Pass Book):** Red Flower Publication Pvt. Ltd.
3. **Address:** 41/48, DSIDC, Pocket-II, Mayur Vihar Phase-I, Delhi – 110 091(India)
4. **Bank & Branch Name:** Bank of India; Mayur Vihar
5. **Bank Address & Phone Number:** 13/14, Sri Balaji Shop,Pocket II, Mayur Vihar Phase- I, New Delhi - 110091 (India); Tel: 22750372, 22753401. **Email:** mayurvihar.newdelhi@bankofindia.co.in
6. **MICR Code:** 110013045
7. **Branch Code:** 6043
8. **IFSC Code:** BKID0006043 (used for RTGS and NEFT transactions)
9. **Swift Code:** BKIDINBBDOS
10. **Beneficiary Contact No. & E-mail ID:** 91-11-22754205, 45796900, E-mail: redflowerppl@vsnl.net

Online You can now renew online using our RFPPL renewal website. Visit www.rfppl.co.in and enter the required information and than you will be able to pay online.

Send all Orders to: **Red Flower Publication Pvt. Ltd.,** 48/41-42, DSIDC, Pocket-II, Mayur Vihar Phase-I, Delhi – 110 091(India). Phone: 91-11-22754205, 45796900, Fax: 91-11-22754205, E-mail: redflowerppl@gmail.com, Website: www.rfppl.co.in

RFP Journal of
Gerontology and Geriatric Nursing

January - April 2018
Volume 1, Number 1

Contents

RFP Journal of Gerontology and Geriatric Nursing

Library Recommendation Form

If you would like to recommend this journal to your library, simply complete the form below and return it to us. Please type or print the information clearly. We will forward a sample copy to your library, along with this recommendation card.

Please send a sample copy to:

Name of Librarian

Name of Library

Address of Library

Recommended by:

Your Name/ Title

Department

Address

Dear Librarian,

I would like to recommend that your library subscribe to the RFP Journal of Gerontology and Geriatric Nursing. I believe the major future uses of the journal for your library would provide:

1. useful information for members of my specialty.
2. an excellent research aid.
3. an invaluable student resource.

I have a personal subscription and understand and appreciate the value an institutional subscription would mean to our staff.

Should the journal you're reading right now be a part of your University or institution's library? To have a free sample sent to your librarian, simply fill out and mail this today!

Stock Manager

Red Flower Publication Pvt. Ltd.

48/41-42, DSIDC, Pocket-II

Mayur Vihar Phase-I

Delhi - 110 091(India)

Phone: 91-11-45796900, 22754205, 22756995, Fax: 91-11-22754205

E-mail: sales@rfppl.co.in

Original Article

RFP Journal of Gerontology and Geriatric Nursing
Volume 1 Number 1, January - April 2018

Identify the Risk Factors Influencing Coronary Artery Disease among the Adult Patients with Coronary Artery Disease in the Cardiology Department of Government Rajaji Hospital, Madurai-20

S. Ponghuzhali*, K. Prem Belwin**

Author Affiliation
*Principal, College of Nursing, Madurai Medical College, Madurai-20.& Ph.D Scholar in Saveetha University, Chennai.
**I Year M.Sc. Nursing, College of Nursing, Madurai, Medical College, Madurai – 20.

Reprint Request
S. Ponghuzhali, Principal, College of Nursing, Madurai Medical College, Madurai- 625020, Tamil Nadu.
E-mail: kuzhaliram@gmail.com

Abstract

Indians suffered a higher rate of cardiac arrest before reaching the hospital. This study was done to identify the risk factors influence in coronary artery disease. This Descriptive study reveals that Co-Morbid factors contribute 25% of High Risk than Psychosocial factors which is 15%. The association of age group indicates that higher the age group in the more risk of CAD. It is found females are higher risk than the males and the normal BMI in adults also has higher risk of CAD when combined with co-morbid factors.

Keywords: Risk Factors; Coronary Artery Disease; Adult Patients; Cardiology Department; Co-Morbid Factors.

Introduction

"An ounce of prevention is worth a pound of cure "

Henry De Bracton -1240

Coronary heart disease is also known as coronary artery disease, and is the most common type of cardiovascular disease Gupta et al (1995, 2002, 2007) have identified various risk factors in the urban community like smoking, obesity, truncal obesity, hypertension, high cholesterol and diabetes to be associated with Atherosclerotic changes begin in the early ages and progress to great extent during adulthood. Physical inactivity, unhealthy habits, eating fast food, unhealthy competition and stress make today's adults vulnerable to CAD. Identifying risk factors among adults, the necessary modification in life style can be introduced early. Second trait of CAD amongst Indians is its severity. A British study7 found that, among patients with myocardial infarction, Indians suffered a higher rate of cardiac arrest before reaching the hospital.

Indians have been known to have a higher prevalence of CAD in presence of low rates of traditional cardiac risk factors like obesity, smoking, cholesterol and hypertension as was demonstrated in the CADI study. This characteristic has been termed. Indian paradox of course, some other traditional risk factors eg, diabetes, physical inactivity, low HDL levels have been shown to have a higher prevalence amongst Indians.

Statement of the Problem

Identify the risk factors influencing coronary artery disease among the adult patients with coronary artery disease in the cardiology department of Government Rajaji Hospital, Madurai-20

Objectives

1. To identify the risk factors that influence coronary artery disease among adult patients .
2. Associate the risk factors with demographic variables.

Hypothesis

1. There is significant relationship between age and coronary artery disease
2. There is significant relationship between body mass index and coronary artery disease.

Assumption

There significant relationship between risk factors and coronary artery disease.

Research Methodology

Research Design

Descriptive design has been adopted.

Population

who have got admitted in the cardiology department with history of myocardial infarction.

Sampling Technique

Non – Randomized convenient sampling techniques was chosen by the investigator

Sample Size

The sample comprises of 20 adult patients (15 male, 5 female) who were admitted in the cardiology department of Govt. Rajai Hospital Madurai-20.

Criteria for Sample Selection

Inclusion Criteria

1. Adult patients diagnosed with coronary artery disease and with history of myocardial infarction.
2. Adult patients under the age group of 20 -50.
3. Adult patients who know to speak Tamil and English.

Exclusion Criteria

1. Adult patients with congenital heart disease
2. Adult patients who have undergone CABG
3. Adult patients admitted in the cardiology Intensive Care

Data Collection Procedures

Permission was obtained from the head of the department of cardiology department. As described I the sample selection procedure, a non randomized convenient sampling techniques was followed to select the sample from cardiology department. The subjects are selected as per the inclusion criteria. The data collection period from 23.2.2011 to 25.2.2011.The investigator initially established rapport and the purpose of the interview was explained and verbal consent was obtained. Each day 6–8 samples were interviewed and the time duration for each interview is about 10-15 minutes. The investigator ensured the privacy, dignity, religious and cultural beliefs were respected during the interview process.

Data Analysis and Interpretation

Assessment of demographic Data of the adult patients having coronary artery disease and Frequency and percentage distribution of demographic data.

Table 1: Assessment of demographic Data of the adult patients having coronary artery disease and Frequency and percentage distribution

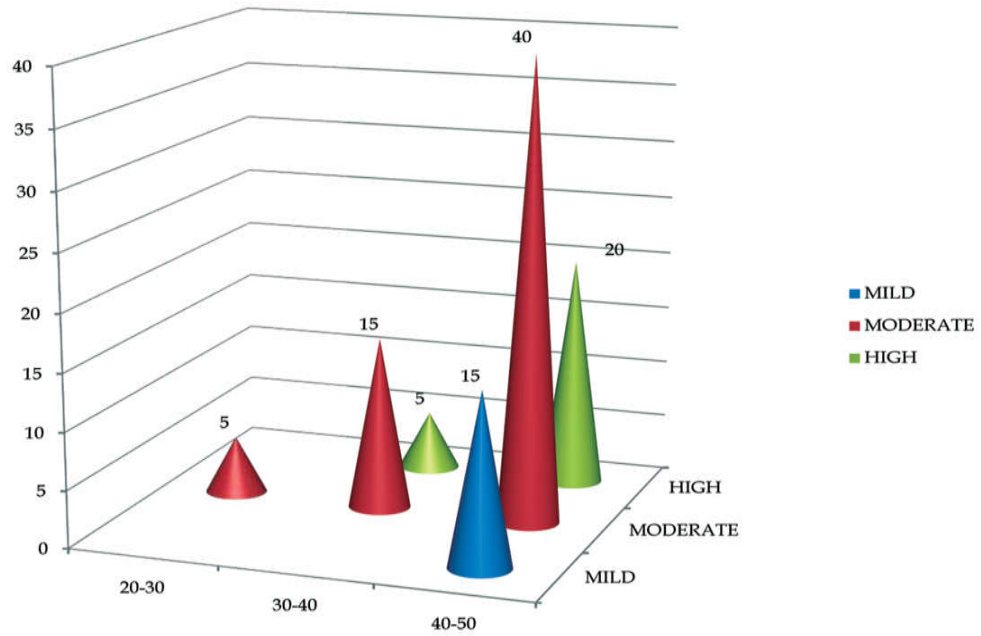
S. No.	Demographic Variable	Frequency	Percentage
1	**Age**		
	a. 20-30 yrs	1	5%
	b. 30-40yrs	4	20%
	c. 40-50 yrs	15	75%
2	**Sex**		
	a. Male	15	75%
	b. Female	5	25%
3	**Education**		
	a. Uneducated	1	5%
	b.Primary education	7	35%
	c.High school	10	50%
	d.Highersecondary	-	
	e.Graduate	2	10%
4	**Occupation**		
	a. Professional	-	-
	b. Clerical work	2	10%
	c. Business	-	-
	d. Labourer	10	50%
	e. Unemployed	8	40%
5	**Family income /mth**		
	a.<Rs 5000	10	50%

	b. Rs 5001-10,000/-	9	45%
	c. Rs 10,001-15,000/-	1	5%
	d.>15000		-
6	**Religion**		
	a. Hindu	19	95%
	b. christian	-	-
	c. muslim	1	5%
	d.others	-	-
7	**Food habits**		
	a.Vegetarian	-	
	b.Non-vegetarian	20	100%
8	**Family type**		
	a. single family	14	70%
	b. joint family	6	30%
9	**Marital status**		
	a. married	19	95%
	b. unmarried	1	5%
10	**Body mass index**		
	a.obese>25.0	10	50%
	b.over weight-23.0-24.9	1	5%
	c.normal -18.5-22.9	9	45%

Association of Selected Demographic Variables with Risk Factors

Table 2: Association of risk factors with age of adults

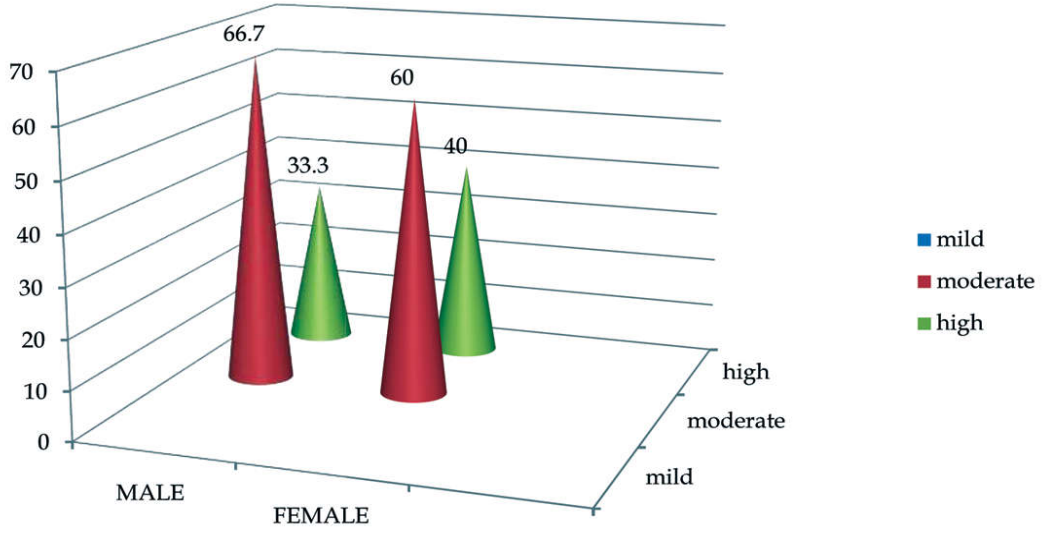
Age	Mild Risk		Moderate Risk		High Risk	
20- 30	-		1	5%		
30- 40			3	15%	1	5%
40 - 50	3	15%	8	40%	4	20%



The Table 3 interprets the association of age group with risk factors in which it shows that the higher the age group the more the risk of getting coronary artery disease rather than the lesser age group.

Table 3 Association of risk factors with sex of adult patients

Age	Mild Risk		Moderate Risk		High Risk	
Male	-	-	10	66.7%	5	33.3%
Female	-	-	3	60%	2	40%

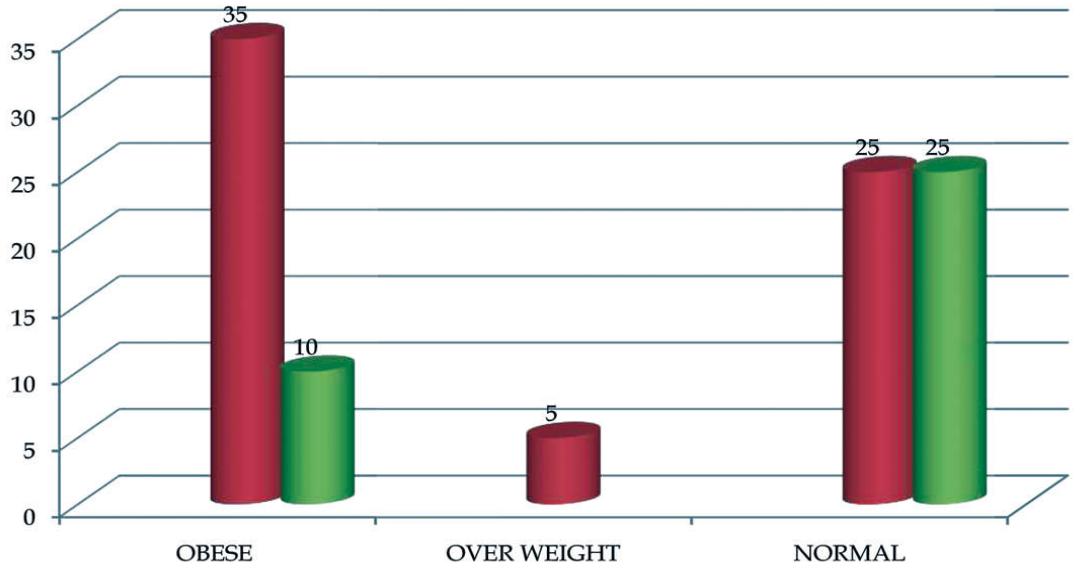


The above chart interprets that females are also at higher risk like the male patients who are in more in moderate risk which may lead to higher risk in future.

Association of Body Mass Index with the Risk Factors

Table 4: Association of Body Mass Index with the Risk Factors

Body Mass Index	Mild Risk		Moderate Risk		High Risk	
Obese	-	-	7	35%	2	10%
Over Weight	-	-	1	5%		
Normal	-	-	5	25%	5	25%



The Table 4 shows that normal body mass index in adult patients also lies in higher risk of coronary artery disease rather than obese patients.

Summary and Recommendations

Creating awareness and imparting and also improving knowledge are foundations in preventing

coronary artery disease, the nurses responsibility is to provide health education to the individual to be an healthy individual and further guide the affected individual who are at more risk in recurrence of the condition with increasing number of risk factors .In order to identify the risk factors and save their lives with creating adequate awareness and health education. With this concept the investigator has selected this project.

The Major Findings of the Study

The comorbid factors were contributing 25% of high risk rather than the psychosocial factors which contribute 15% of high risk factors but both go hand in hand in increasing the incidence 15% of psychosocial factors and 85% of it influence coronary artery disease 15% of psychosocial factors and 85% of it influence coronary artery disease. the association of age group with risk factors in which it shows that the higher the age group the more the risk of getting coronary artery disease rather than the lesser age group. that females are also at higher risk like the male patients who are in more in moderate risk which may lead to higher risk in future. normal body mass index in adult patients also lies in higher risk of coronary artery disease rather than obese patients.

Nursing Implications

Implications for Nursing Practice

This study also implied the needs for integrated series feedback, follow up in collaborative approach of both hospital and individual. The concept that has to be changed which implies the need for change that has to be introduced from within the patient's expectations and needs.

Implication for Nursing Education

Nurses should update knowledge in prevention of coronary heart disease which starts with the knowledge of causative factors and their management also.

Implications to Nursing Administration

The nurse administrators should take active part in the health policy making developing protocols, procedures,**sta**nding orders related to coronary artery disease.

Implications for Nursing Research

The study helps the nurse researcher to develop insight into the identification and prevention of coronary artery disease.

Recommendation

- Replication of this study may be done in different settings.
- A comparative study may be conducted among the male and female populations.
- A study can be conducted to assess the level of anxiety among the family members.
- Nurses working in the cardiology department should spend adequate time in meeting the physical and physiological needs of the patients.

Conclusion

An overall perusal of the results and discussion of this study has brought about he conclusion of the risk factors influencing coronary artery disease among adult patients .The health of the adult patient is essential in leading a healthy life and reduce the mortality rate .The reduction of the disability caused by the coronary artery disease is very much preventable through effective participation of the patient and the nurse. Adequate knowledge about the disease and the proper follow up care which also includes appropriate life style modification and the control of associated diseases which acts as the major factors in influencing coronary heart disease .

References

1. Brunner &Suddharth Text book of Medical surgical Nursing 11th edition Volume 1 Published by Wolters Kluwer private limited New Delhi. pp00- 880.
2. Critical Care Joseph M.ciretta,RobertW.Taylor copyright 1988 published by J.B Lippincott company pp1161-1178
3. Clinical nursing skills, Presented in the nursing process basics to advanced skills, Sandrasmith, DonnaJ. Dwell national nursing review. pp677-681.
4. Medical Surgical Nursing,clinical management for continuityof care .Joyce M Black Esther Matassarin Jacobs 5th Edition Pg no 1200 -1258
5. Intensive Medical Care PoisonManagement and Basic life support , course material Tamilnadu health system project. pp177 -179.
6. The Washington Manual of Medical therapeutics Daniel H Cooper ,Andrew J Krainik Sam J. Lubner, Wolters Kluwer PVT. Ltd Lippincott Williams, 2nd

IndianReprint. 2008; 229-238.

7. Lippincott of Manual Nursing Practice Sandra M. Nettina, Ninth Edition Published by Wolters Kluwer (india) Pvt. Ltd., New Delhi. pp.800 - 806
8. Sharon Mantik Lewis, Margaret Heitkemper, Medical Surgical Nursing Assessment and Management of Clinical Problems Sixth Edition Published by Mosby St. Louis, Missouri. pp.1217–1228.
9. Clinical Manual of Medical Surgical Nursing Concepts and Clinical Practice, Judith K. Sands, Pamela E. Dennison fifth Edition Published by Mosby St. Louis, Missouri. pp. 278–285.
10. Internet source http: // en.wikipedia. org , http: // medind. nic.in , www. allindia. nurses. Com.

Review Article

RFP Journal of Gerontology and Geriatric Nursing
Volume 1 Number 1, January - April 2018

Aromatherapy: Treating with Smell in Elderly

Vineeth Joseph

Author Affiliation
Asst. Professor, St. Thomas College of nursing, Chethipuzha, Kurishumoodu P. O, Changanacherry, Kottayam, Kerala- 686501.

Reprint Request
Vineeth Joseph, Asst. Professor, St. Thomas College of nursing, Chethipuzha, Kurishumoodu P. O, Changanacherry, Kottayam, Kerala- 686501.
Email: wittyvineeth@gmail.com

Abstract

Aroma means smell. Smell and odors is used as a part of mind body modalities under the alternative system of health care. Aromatherapy is the practice of using natural oils which is extracted from flowers, bark, stems, leaves, roots or other plant parts to enhance psychological and physical well being. Essential oils are extracted from variety of different parts of plants by different methods. It can be used for treating different health ailments. The different essential oils have its peculiarities for the treatment. It is mostly used along with the carrier oils to reduce its irritating effects. The use of aromatherapy can be made by different simple methods like massage, bath etc. But while caring the elderly precautions can be taken in order to maximize its effect as well as reduce the side effects.

Keywords: Aromatherapy; Elderly; Smell; Essential Oil; Carrier Oil.

Aroma means smell. Smell and odors is used as a part of mind body modalities under the alternative system of health care. The use of aromatherapy dates back to ancient times for the purpose of treatment all over the world. Now a day it is widely used in all the streams. Essential oils have been used for therapeutic purposes for nearly 6,000 years. In the history Chinese, Indians, Egyptians, Greeks, and Romans used them in cosmetics, drugs, perfumes and also for spiritual, therapeutic, hygienic, and ritualistic purposes. The term aromatherapy was coined by French Chemist Rene-Maurice Gaffefosse in 1928 which shows healing effect on burns by lavender oil.

Aromatherapy is the practice of using natural oils which is extracted from flowers, bark, stems, leaves, roots or other plant parts to enhance psychological and physical well being. The vital element of aromatherapy is the essential oils. Essential oils have been used for the generations to ease symptoms of depression, anxiety, insomnia to boost memory and mood. The inhaled molecules of aroma react with nerves in the olfactory bulb and relay nerve messages to the limbic system mostly amygdala and hippocampus that serve as storehouses and control area for emotions and memories or are absorbed into the blood stream by thin membranes of the nose, bronchioles and lungs. Some researchers show that they may interact in the blood with hormones or enzymes. It is also now well accepted that essential oil components can be absorbed through the skin to reach internal organs. The limbic system is directly connected to the parts of the brain that control heart rate, blood pressure, breathing, memory, stress levels, and hormone balance. There are several studies that shows oil fragrances may be one of the fastest ways to bring about, physiological or psychological effects.

How It Is Made

Essential oils are extracted from variety of different parts of plant, by distillation, maceration, effleurages and pressing.

Parts Plants Yielding Essential Oil

Parts of Plant	Essential Oil
Flowers	Jasmine, Rose, Ylang, Neroli
Leaves	Citronella, Lemongrass, Palmaroa
Bark	Cinnamon
Roots	Ginger, Vetiver
Entire Plant	Geranium, Lavender, Rosemary
Fruit Peel	Beragmot, Lemon, Lime, Sweet Orange

Common Essential Oil and Its Use

Lavender: said to be calming and to balance emotions. Also antidepressant, insomnia, Alzheimer disease. Used undiluted to treat burns, migraine, infuria. Reduce cortisol levels.

*Lemon Balm***:** (melissa officinalis)-help to calm and relax people who are dealing with anxiety and insomnia.

Pepper Mint: alleviate symptoms of anxiety and depression. Used to stimulate the mind and the calm nerves. Treat absent mindedness, improve memory & mental performance. Boost Energy Level, regulate digestive tract and reduce inflammation.

Rosemary: Reduce cortisol levels. Stimulate body and mind. De- stress after they are related with feelings & contentment. Proven to help with memory and dementia & memory lose.

Bergamot: Mood elevating, Calming, and balancing. Used to relieve anxiety, agitation, mild depression and stress. Used to relieve insomnia.

Ginger: helpful for anyone struggle with digestive issue. Used to treat loss of appetite & constipation. Promote eating habits.

Rose: promote skin cell regeneration. Beauty tool that improve senior complexions. Soften lines and wrinkles of facial skin. Used for antidepressant and mood boosting. Have antiviral and antibacterial properties.

Eucalyptus: It is an antiseptic, aids in circulation and oxygenation. Guards against respiratory infection. Natural treatment of sinusitis and headache.

Lemon: effect like anti depressant. Best natural choice for those who are stressed, tensed or suffering from anxiety. Helps to lower blood pressure, reduces cellulites.

Carrier Oil

Carrier oil otherwise called as base oil is used to dilute essential oils before they are applied to the skin in massage and aromatherapy.

It is mostly derived from the fatty portion of a plant, usually from the seeds, kernels or the nuts. It is essential to use some carrier oil for the use of essential oil because the concentrated form of essential oil is harmful to body which causes severe irritation, sensitization, redness or burning or other reactions in some individuals.

Almond Oil, Aloe Vera Oil, Apricot Oil, Avocado Oil, Grape seed Oil, Hazelnut Oil, Jojoba Oil, Olive Oil, Walnut Oil etc are the most commonly used carrier oils.

Methods of Use

Essential Oils are mostly inhaled and absorbed into the lungs.

Also can be applied to skin

- Facial Oil
- Body Oil
- Bath/Shower
- Body lotion
- Foot/Hand Bath
- Hair Care
- Sitz Bath
- Ambient diffusion
- Compress
- Massage
- Misting
- Pillow Talk.
- Direct Inhalation-Scented Candles
- Compressor.

Precautions for Elders

- Use under the guidance of a specialist.
- Elders who have respiratory problems use it precautionary as the exposure can predispose attacks of asthma and allergy.
- Use essential oil directly along with a carrier oil/ blending oil.
- A precaution with each oil is different. So use wisely.
- As elders are frail use a lower dilution state for essential oil.
- It can interact with some medication. So judicious with its use.
- While giving massage always give gently as skin of elders are thin.
- Keep in safe custody because dementia is a major problem in elderly. So mistakes can happen.
- Essential oils are highly volatile and flammable so they should never be used near an open flame.

Health Issues and Essential Oils that Can Be Used for Elderly

Restlessness and poor sleep-	Lavender, Marjoram Sweet Lemon.
Loss of Appetite-	Cardamom, Rosemary, Lemon, Ginger.
Constipation-	Ginger, Rosemary, Orange.
Diarrhea-	Peppermint, Geranium.
Indigestion.	Mandarin, Lemon, Peppermint.
Anger, Aggression, Irritability-	Lavender, Melissa.
Anxiety, Agitation-	Neroli, Lavender, Geranium.
Apathy-	Rose.
Depression-	Bergamont, Geranium, Grapefruit, lavender, Lemon, Orange, Rose, Rosemary.
Headache-	Lavender, Chamomile Roman.
Memory-	Rosemary, Lemon.
Muscle Contraction-	Lavender, Juniper Berry.
Common Cold-	Lavender, Eucalyptus, Lemon.
Arthritis-	Lavender, Lemon, Roman Chamomile.
Dry Cracked Skin-	Lavender.

Scientific Evidence for Treatment

- Bed ridden or wheel chair bound persons can benefit from aromatherapy massage.
- Lavender helps in the improvement in quality of sleep.
- Lavender Aromatherapy reduces falls in elderly nursing home residents.
- Aromatherapy massage reduces pain, physical function, sleep disturbance and depression in elderly women with osteoarthritis.
- The effect of lavender aromatherapy on cognitive function, emotion, and aggressive behavior of elderly with dementia.
- Aromatherapy helps to reduce the symptoms of Alzheimer's disease.
- Aromatherapy massage helps to relieve anxiety, constipation among elderly.
- Aromatherapy helps in alleviating problems related with arthritis.
- Aromatherapy helps in relieving problems related with arthritis.

Conclusion

Aromatherapy is very effective for elders both in physical symptom relief and psychological effect. It is important to know well in advance before start treating with nature's medicine. When used properly aromatherapy is safe, simple and effective for many at home and also for caregivers.

Key Messages

Aromatherapy is the use of smell and essential oil for the different health ailments. Its use is widely increasing in the modern world. With efficient practice it can be applied for the elderly people so that they will be benefited with this during the stage of discomforts.

References

1. Ballard CG, Gauthier S, Cummings JL, Brodaty H, Grossberg GT, Robert P, Lyketsos CG. Management of agitation and aggression associated with Alzheimer disease. Nat Rev Neurol. 2009 May; 5(5):245-55. Review.
2. Dunning T. Applying a quality use of medicines framework to using essential oils in nursing practice. Complement Ther Clin Pract. 2005; 11(3): 172-81.
3. Edris AE. Pharmaceutical and therapeutic potentials of essential oils and their individual volatile constituents: a review. Phytother Res. 2007; 21(4): 308-23.
4. Fellowes D, Barnes K, Wilkinson S. Aromatherapy and massage for symptom relief in patients with cancer. Cochrane Database Syst Rev. 2004; (2): CD002287.
5. Hadfield N. The role of aromatherapy massage in reducing anxiety in patients with malignant brain tumours. Int J Palliat Nurs. 2001; 7(6):279-85.
6. Herz RS. Aromatherapy facts and fictions: a scientific analysis of olfactory effects on mood, physiology and behavior. Int J Neurosci. 2009; 119(2):263-90. Review.
7. Hu PH, Peng YC, Lin YT, Chang CS, Ou MC. Aromatherapy for reducing colonoscopy related procedural anxiety and physiological paramters: a randomized controlled study. Hepato-gastroenterology. 2010; 57(102-102):1082-6.
8. Krebs M. Promote wellness with aromatherapy.

Adv Nurse Pract. 2006; 14(5):41-4.

9. Kuriyama H, Watanabe S, Nakaya T, et al., Immunological and Psychological Benefits of Aromatherapy Massage. Evid Based Complement Alternat Med. 2005; 2(2):179-184.
10. Kyle G. Evaluating the effectiveness of aromatherapy in reducing levels of anxiety in palliative care patients: results of a pilot study. Complement Ther Clin Pract. 2006; 12(2):148-55.
11. Lee CO. Clinical aromatherapy. Part II: Safe guidelines for integration into clinical practice. Clin J Oncol Nurs. 2003; 7(5):597-8.
12. Lewith GT, Godfrey AD, Prescott P. A single-blinded, randomized pilot study evaluating the aroma of Lavandula augustifolia as a treatment for mild insomnia. J Altern Complement Med. 2005; 11(4):631-7.
13. Lin PW, Chan WC, Ng BF, Lam LC. Efficacy of aromatherapy (Lavandula angustifolia) as an intervention for agitated behaviours in Chinese older persons with dementia: a cross-over randomized trial. Int J Geriatr Psychiatry. 2007; 22(5):405-10.
14. Maddocks-Jennings W, Wilkinson JM. Aromatherapy practice in nursing: literature review. J Adv Nurs. 2004; 48(1):93-103.
15. Mercier D, Knevitt A. Using topical aromatherapy for the management of fungating wounds in a palliative care unit. J Wound Care. 2005; 14(10):497-8, 500-1.
16. Perry N, Perry E. Aromatherapy in the management of psychiatric disorders: clinical and neuropharmacological perspectives. CNS Drugs. 2006; 20(4): 257-80.
17. Rho KH, Han SH, Kim KS, Lee MS. Effects of aromatherapy massage on anxiety and self-esteem in korean elderly women: a pilot study. Int J Neurosci. 2006; 116(12):1447-55.
18. Thorgrimsen L, Spector A, Wiles A, Orrell M. Aroma therapy for dementia. Cochrane Database Syst Rev. 2003; (3):CD003150.
19. Kim MJ, Nam ES. Aromatherapy of patients with arthritis. Journal of muscle and joint health. 2004; 11(1):7-17.
20. Choi IR. Effects of aromatherapy massage on pain, physical function, sleep disturbance and depression in elderly women with osteoarthritis. Korean Journal of Women Health Nursing. 2006 Jun 1; 12(2):168-76.
21. Lee SY. The effect of lavender aromatherapy on cognitive function, emotion, and aggressive behavior of elderly with dementia. Taehan Kanho Hakhoe Chi. 2005 Apr; 35(2):303-12.
22. Jimbo D, Kimura Y, Taniguchi M, Inoue M, Urakami K. Effect of aromatherapy on patients with Alzheimer's disease. Psychogeriatrics. 2009 Dec 1; 9(4):173-9.
23. Kim MA, Sakong JK, Kim EJ, Kim EH. Effect of aromatherapy massage for the relief of constipation in the elderly. Taehan Kanho Hakhoe Chi. 2005 Feb; 35(1):56-64.
24. Ballard CG, O Brien JT, Reichelt K, Perry EK. Aromatherapy as a safe and effective treatment for the management of agitation in severe dementia: the results of a double-blind, placebo-controlled trial with Melissa. Journal of clinical Psychiatry. 2002 Jul 7; 63(7):553-8.
25. Brooker DJ, Snape M, Johnson E, Ward D, Payne M. Single case evaluation of the effects of aromatherapy and massage on disturbed behaviour in severe dementia. British Journal of Clinical Psychology. 1997 May 1; 36(2):287-96.

Review Article

RFP Journal of Gerontology and Geriatric Nursing
Volume 1 Number 1, January - April 2018

Elder Mistreatment: Prevent it

Shaina Sharma

Author Affiliation:
Nursing Tutor, AIIMS, Rishikesh.

Reprint Request:
Shaina Sharma
Nursing Tutor, AIIMS, Rishikesh,
Shivaji Nagar, Near Bairraj Lake,
Veerbhadra, Rishikesh,
Uttarakhand 249202
E-mail:
sharma_shaina@hotmail.com

Abstract

Elder mistreatment is growing problem worldwide. There are various factors associated with it such as generation gap, life style changes, chronic disabilities of elders, career ambitions of younger generation; all these factors have affected the care of the older people. Elder abuse may include physical, psychological, sexual, financial abuse and neglect. It can lead to different consequences physically, psychologically and financially. Awareness on the part of elders and members of the society is must to prevent elder abuse from happening. The reporting of the elder abuse and recognizing the signs of elder abuse are the other important aspects of elder abuse.

Keywords: Mistreatment; Abuse; Awareness; Neglect.

Introduction

An elder person is that who is of 60 years of age or older. The population of elderly people is increasing in India. According to a report, at present there are 77 million older people in our country and this is going to increase up to 177 million in the coming 25 years. This may be because the life expectancy has increased from 40 years to 64 years. It may affect the financial, shelter and health aspects of the care [1]. The generation gap between the younger generation and older generation, life style changes, chronic disabilities of elders, career ambitions of younger generation; all these factors have affected the care of the older people. The younger generation may perceive them as a burden than a responsibility which may lead to certain kind of elder abuse.

A study conducted Helpage India conducted a study to understand the elder abuse, its prevalence in different cities and perceptions of elderly. This study found that one third of the elderly experienced the elder abuse. Other findings of the study were; Most of the elderly population is financially dependent on others and many of them feel that the constituents of elder abuse are emotional abuse, verbal abuse, physical abuse, economic abuse and showing disrespect. Many of the elderly experienced one or the other type of abuse with highest incidence reported in Bhopal, followed by Chennai and kolkata [2].

Definition

Elder mistreatment is also known as elder abuse. According to WHO elder abuse is defined as "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person"[3].

Types of Elder Abuse

- *Physical Abuse:* This type of abuse refers to use of the physical force intentionally which may lead to the trauma, injury, acute or chronic illnesses, impairment of the functional abilities or death.
- *Sexual Abuse:* It includes the forced touching or non-touching kind of acts with the elder person. Any kind of unwanted sexual interaction comes under sexual abuse if committed against the incapacitated people who are incompetent to provide informed approval.
- *Psychological Abuse:* The verbal or nonverbal kind of behavior which may result in the anger, mental

Pain, anxiety, or distress among elders.

- *Domestic Violence:* Violence used by the care provider to exercise power and control.
- *Neglect:* If the care provider fails to protect an elder from harm, does not meet needs for necessary medical care, adequate nutrition, hydration, hygiene or cleanliness, clothing and shelter, which may lead to serious risk of compromised health and safety; comes under the neglect.
- *Financial Abuse:* This refers to the illegal or improper use of the elder person's resources by the care provider for the benefit of others than the elder person [4].

Consequences of Elder Abuse

- *Physical Effects*

- Wounds and injuries
- Physical pain
- Sleep disturbances
- Susceptibility to new illnesses
- Exacerbation of preexisting health conditions
- Increased risks for premature death

- *Psychological Effects*

- Increased levels of distress and depression.
- Increased risks for developing fear and anxiety reactions
- Helplessness
- Posttraumatic stress disorder

- *Sexual Abuse*

- Bruises around breasts or genitals
- Genital infections or STDs
- Unexplained bleeding from anus or vagina
- Torn and bloody underclothing

- *Neglect*

- Unusual weight loss
- Malnutrition and dehydration
- Untreated physical problems e.g. bed sores
- Unhealthy living conditions: dirt, bugs, soiled bedding and clothes
- Unhygienic conditions such as left dirty or unbathed
- Unsuitable clothing in accordance with weather conditions
- Risky living conditions

- *Financial Exploitation*

- Sudden changes in financial condition of older person
- Doubtful changes in wills and power of attorney
- Pending bills or lack of medical care
- Cash or items stolen/missing from home

Prevention of Elder Abuse

Recognizing the Signs of Abuse

- *In an Older Adult:* Be watchful for an older person who seems to be in the problem situation but is reluctant talk about it or answer the related questions. Also look for hungry &unclean appearance, scared of his or her caregiver, bruised, ill/sick, neglected, or often confused, all these factors indicate abuse. Other factors to consider are; lack of interest in activities that he or she used to enjoy, or strange nervousness.
- *In a Caregiver:* If the caregiver tries to dominate an older adult and is verbally or physically abusive to the older person, it indicates the abuse.
- *In the Home:* If an elderly person or caregiver does not allow the others to come to their home then there may be a problem. Other signs include an accumulation of newspapers and mail, home in a state of disrepair, odd noises or bad odors coming from the home [5].

The Maintenance and Welfare of Parents and Senior

It extends to the whole of India except the State of Jammu and Kashmir and it applies also it citizens of India outside India. After being passed by the parliament of India received the assent of President of India on December 29, 2007 and was published in the Gazette of India on December 31, 2007. According to this act it is the legal obligation for children to provide maintenance to senior citizens and parents, by monthly allowance. This Act also provides simple, speedy and inexpensive mechanism for the protection of life and property of the older persons [6].

International Day of Elderly

This day is celebrated on 1st of October to appreciate the contributions of elderly people to the society and also to raise the awareness regarding the

issues of elderly such as elder abuse [7].

Responsibilities of Care Giver to Prevent the Elder Abuse

- Request for help from others (friends/relatives/ local care agencies)
- Find an adult day care program
- Stay healthy and never necessary get medical care
- Indulge in stress reduction activities
- Seek counseling/help for depression
- Find out support group for caregivers of the older persons
- In case of drug or alcohol abuse, seek help.

Responsibilities of Concerned Family Friend to Prevent the Elder Abuse

- Watch for the warning signs of elder abuse and report accordingly.
- Check the elder's medications, amount in the vial and date of the prescription
- Watch for possible signs of financial abuse.
- Try to visit or call the elderly person as often as you can.

Responsibility of the Elderly Person

In case of the elder abuse, it is the responsibility of the elderly person to report it. Reporting to a trustable person (family member/family friend/doctor) is essential.

Conclusion

Elder mistreatment and abuse has become a major health concern. Magnitude of the problem is still underestimated. The routine screening of the elderly persons must be done to assess for the elder abuse. Mass awareness programmmes must be organized to create awareness about elder abuse. Government funding schemes must provide for all the essential requirement of life.

References

1. Shubha Soneja. Elder Abuse in India, Country Report for World Health Organization. Accessed on: 6th July, 2016. Available at: http://www.who.int/ageing/projects/elder_abuse/alc_ea_ind.pdf
2. Report on elder abuse in India. Helpage India. Accessed on: 6th July, 2016. Available at: https://www.helpageindia.org/images/pdf/ElderAbuseIndia10.pdf
3. Elder abuse. Ageing and life course. World health organization. 2016. Accessed on: 6thjuly. Available at: http://www.who.int/ageing/projects/elder_abuse/en/
4. Elder Abuse: Definitions. Injury Prevention & Control: Division of Violence Prevention. Centers for Disease Control and Prevention. April 5, 2016. Available at:http://www.cdc.gov/violenceprevention/elderabuse/definitions.html
5. Preventing Elder Abuse and Neglect in Older Adults. 2016.Available at: http://www.healthinaging.org/resources/resource: preventing-elder-abuse-and-neglect-in-older-adults/
6. The maintenance and welfare ofparents and senior citizens act, 2007 no. 56 of 2007. Ministry of law and justice (Legislative department). Accessed on: 6th July, 2016. Available at:https://www.google.co.in/search?sclient=psy-ab&biw=1366&bih=679&noj=1&q=Parents+and+Senior+Citizens+Bill%2C+2007&oq=Parents+and+Senior+Citizens+ Bill%2C+2007&gs_l=serp.3.0j0i22i30 l2.1112029.1115510.1.1116244.25.8.0.0.0.0.387.703.3-2.2.0....0...1c.1j2.64.serp..23.2.700...0i67.NOA_CBiaprc.
7. 1 October: International Day of Older Persons. Ageing and life course. World health organization. 2016. Accessed on: 7th july. Available at: http://www.who.int/ageing/events/idop_rationale/en/

Review Article

RFP Journal of Gerontology and Geriatric Nursing
Volume 1 Number 1, January - April 2018

Falls in the Elderly

Anjali Sancha

Author Affiliation:
Lecturer, College of Nursing, All Indina Institute of Medical Sciences (AIIMS) Patna.

Reprint Request:
Anjali Sancha, Lecturer, College of Nursing, All Indina Institute of Medical Sciences (AIIMS) Patna, Phulwarisarif, Patna–801507, Bihar.
E-mail: sancha.anjali@gmail.com

Abstract

Falls are one of the major problems among the geriatric population and are a marker of poor physical and cognitive status. The current practice generally focuses on the injury rather than a complete assessment of underlying cause. If the risk factors are identified early and screening is done to high risk elderly then, majorities of the falls are potentially preventable.

Keywords: Elderly; Falls; Intrinsic Factors; Extrinsic Factors; Preventable; Environment**.**

Introduction

The global population of people aged 60 years & older, would be more than double, i.e. from 542 million in 1995 to about 1.2 billion in 2025 [1]. And in India, geriatric population will reach up to 198 million in 2030 (union health ministry report), which is the area of concern, especially their health with medical and psychological problems. Falls are one of the major problems in the elderly and considered one of the "Geriatric Giants" (in mobility, instability, incontinence and impaired intellect/memory).

Definition

Falls are defined as inadvertently coming to rest on the ground, floor or other lower level, including intentional change in position to rest [2]. The fall discussed include slips and trips occurring both inside and outside the home.

Epidemiology

According to WHO 2016 fact sheet, falls are the second leading cause of accidental or unintentional injury death worldwide. Each year an estimated 424000 individuals die from falls globally, in which 80% are from low and middle- income countries. Incidences shows that rates from falls increase with age group 65-74 years, men have higher death rates than women, but after the age of 75, women are more prone to die as a result of fall. Most of the cases are found to unreported by older people, just because they are accepted as "normal" during old age. Many studies also reveal that there is the higher prevalence of osteoporosis among older women, which make them more likely to have fall related fractures. About 40% post fall cases, who were hospitalized due to hip fracture, could not return to normal living.

Risk Factors

Several risk factors are found to be associated with fall. It can be intrinsic, extrinsic and situational.

Intrinsic factors include impairment in maintaining balance and stability while standing, walking, or sitting. The decrease in visual acuity, contrast sensitivity, depth perception and dark adaptation, consumption of psychoactive drugs, & some disease conditions like Alzheimer's, Parkinson's, depression, dementia, orthostatic hypotension & musculoskeletal problems, also adds on to the risk of fall among geriatrics.

Extrinsic factors include presence of hazards like loose carpets, slippery surfaces, glare surfaces, unstable furniture, pets, clutter, cords in pathway, absence of support (in the chair, handrails, grab bars), lack of adequate lighting, improper foot wares, inappropriate mobility devices etc.

Situational factors includes certain activities like

rushing to the bathroom (especially during the night when a light is not adequate), rushing to answer the telephone and while walking with high heels.

Assessment

Identification of the risk factor plays an important role in the prevention of fall among elderly.

Risk Factors to Assess Includes

- History of previous fall
- Age
- Gender
- Medical conditions especially for osteoporosis (in women)
- Cognitive impairment
- Balance and gait
- Ambulatory aids
- Environmental hazards
- Vision
- Systolic hypotension
- Periodic medication review

The most important part of a fall risk assessment is to identify a person's individual risk profile and tailor interventions to those risk factors. Assessment in depth will help us to rule out the risk and to take better prevention strategies. Assessment of environmental hazards is also very necessary to find out. Getting an in-home safety evaluation from an occupational therapist or healthcare provider can be beneficial.

Interventions

Patient and Family Education

How to get up from a fall:

- Locate a sturdy piece of furniture
- Roll over onto your side
- Push your upper body up
- Crawl on your hands and knees
- Put your hands on the chair seat
- Slowly rise from the kneeling position
- Turn your body to sit in the chair
- Regain your composure

If you can't get up, then:

- Cry out
- Bang away
- Slide over to a telephone
- Get into a comfortable position and wait

Prevention

Fall prevention strategies should be comprehensive and multifaceted. Public health initiative should define the burden, explore variable risk factors and utilize effective prevention strategies. They should support policies that create safer environments and reduce the risk of fall.

Four Things you can do to Prevent Falls

- Begin a regular exercise/yoga (Tai Chi) program: it has been found that exercises that build, balance and lower- body strength, reduces the risk of falls by 33%.
- Review of medications and regular follow -up check up should be done.
- Get your vision checked by an eye doctor atleast once in a year.
- Make your home safer by:
  - Installing handrails on both sides of stairways
  - Marking first & the last step with tape or paint
  - Install grab bars near shower, next to toilet
  - Install elevated seat on toilet

Conclusion

Elder population is at high risk of fall leading to increasing number of morbidity and mortality. Recurrent falls due to intrinsic factors need overall evaluation of the underlying medical condition and require preventive measures. A majority of falls are predictable and therefore preventable.

References

1. Jensen J et al. Fall and injury prevention in older people living in residential care facilities. Annals of Internal Medicine, 2002; 136(10):733-41.
2. Close J, Ellis M, Hooper R et al. Prevention of falls in the elderly trial (PROFET): a randomized controlled trial. Lancet, 1999; 353:93-97.

3. KumarA et al. The problems of fall, risk factors and their management among geriatric population in India; Indian Journal of Community Health, 2013 April-June; 25(2).
4. Kannus P et al. Prevention of hip fracture in elderly people with use of a hip protector. New England Journal of Medicine, 2000; 343(21):1506-1513.
5. Kiely DK et al. Identifying nursing home residents at risk for falling. Journal of the American Geriatrics Society, 1998; 46(5):551-55
6. Rubenstein LZ. The importance of including the home environment in assessment of frail older persons. J Am Geriatr Soc, 1999; 47:111-112.
7. Stevens VJ, et al. Design and implementation of a falls prevention intervention for community-dwelling older persons. Behavior and Health in Aging, 1992; 2:57-73.

STATEMENT ABOUT OWNERSHIP AND OTHER PARTICULARS
"RFP Journal of Gerontology and Geriatric Nursing" (See Rule 8)

1. Place of Publication	:	Delhi
2. Periodicity of Publication	:	Quarterly
3. Printer's Name	:	**Asharfi Lal**
Nationality	:	Indian
Address	:	3/258-259, Trilok Puri, Delhi-91
4. Publisher's Name	:	**Asharfi Lal**
Nationality	:	Indian
Address	:	3/258-259, Trilok Puri, Delhi-91
5. Editor's Name	:	**Asharfi Lal** (Editor-in-Chief)
Nationality	:	Indian
Address	:	3/258-259, Trilok Puri, Delhi-91
6. Name & Address of Individuals	:	**Asharfi Lal**
who own the newspaper and particulars of shareholders holding more than one per cent of the total capital	:	3/258-259, Trilok Puri, Delhi-91

I Asharfi Lal, hereby declare that the particulars given above are true to the best of my knowledge and belief.

Sd/-
(Asharfi Lal)

Subscription Form

I want to renew/subscribe international class journal **"RFP Journal of Gerontology and Geriatric Nursing"** of Red Flower Publication Pvt. Ltd.

Subscription Rates:
• Institutional: INR5500/USD430
• Individual: Contact us

Name and complete address (in capitals):

Payment detail:
Demand Draft No.
Date of DD
Amount paid Rs./USD

1. Advance payment required by Demand Draft payable to Red Flower Publicaion Pvt. Ltd. payable at Delhi.
2. Cancellation not allowed except for duplicate payment.
3. Agents allowed 10% discount.
4. Claim must be made within six months from issue date.

Mail all orders to
Red Flower Publication Pvt. Ltd.
48/41-42, DSIDC, Pocket-II
Mayur Vihar Phase-I
Delhi - 110 091(India)
Phone: 91-11-45796900, 22754205, 22756995, Fax: 91-11-22754205
E-mail: sales@rfppl.co.in
Website: www.rfppl.co.in

RFP Journal of Gerontology and Geriatric Nursing
Volume 1 Number 1, January - April 2018

Letter to Editor

Dear Sir,

The author from the Department of Community Medicine KVG Medical College organized a Geriatrics and Gerontology Quiz for postgraduates of Community Medicine of 7 private Medical Colleges of Dakshina Kannada District of Karnataka in August 2013 from 2.00-4.00 pm IST (Indian Standard Time) [1]. All the college students were aware about the quiz 2 months in advance. The Aim of the quiz was to make the Postgraduate students of Community Medicine aware of the extent of the problem, reasons for the rise in number, how it will affect our economy and health care, issues involved, after effects, and role of family, society and Government and NGOs and International Organizations. It had four rounds which are as given below

First Round: 10 questions: Multiple Choices: 4 options. Choose the most appropriate option. No negative marks. 1 mark per correct answer was given. No elimination. Marks were carried over to the next round of the Quiz.

2nd Round: 10 questions: Fill in the Blanks (No negative marks. 1 mark / correct answer) No elimination. Total Marks of two rounds carried over to the next round

Third Round: Buzzer Round: (Elimination round begins) Assertion and Reasoning type: 10 questions (2 marks for correct answer & -1 mark for incorrect answer.) Given below are paired statements. Statement A = (Assertion), Statement R = (Reason).

Select Appropriate Answer using the Code Given Below

a. Both A (Assertion) and R (Reason) are true and R (Reason) is the correct explanation of A (Assertion).

b. Both A (Assertion) and R (Reason) are true, but R is not the correct explanation of A.

c. A (Assertion) is true, but R (Reason) is false.

d. A (Assertion) is false, but R (Reason) is true.

Three Teams were Informed to Remain in Competition at the End of This Round. The Rest were Eliminated

4th Round: Rapid fire round: (part 1) (Common for all teams) All 5 questions will be simultaneously given to all teams. The teams were informed to answer as many questions as possible in 3 minutes. 2 marks were given for correct answer and 1 mark was given for incorrect answer). Two teams were informed to remain at the end of this round.

5th Round: Rapid fire round (Individual Team) Answer if true or false. 1 marks per correct answer. 1 negative mark was given for an incorrect answer. 2 minutes per team. 10 question per team.

The questions were displayed as power point presentation to the teams and audience. During the competition the answer for the question were supported by an authentic reference from a book or journal which is also given below. The quiz was followed by prize distribution.

At the end of the Quiz opinion of the students regarding the quiz was collected. In total 20 PG students attended the Quiz. The following positive findings were obtained 70% of the students liked the Quiz very much, 15% liked it somewhat and 15% did not like it. The reason given by those who did not like was that some questions were bit tough to understand and were out of syllabus. 100% found the quiz to be informative. The overall conduct of the quiz was clear to 70% of the students. 100% felt that, the quiz was conducted in a fair manner. 50% of the students liked the first two rounds, the rest 50% liked rapid fire round. 60% of the students felt that the quiz had enough applied questions. 80% felt that most topics were effectively covered in the quiz. 20% found that more questions should have been asked on Clinical Aspects of Geriatric Medicine. 90% were motivated to study more after the quiz. 10% said that they have already decided to pursue other disciplines as their career. 100% felt that quiz was an effective method of teaching Geriatric Medicine. 70% said that their perception regarding the subject changed after the quiz.

They said that they considered it as just a small subject in Community Medicine. Now after the quiz they had understood that it is important for all the clinical disciplines to learn about this subject in near future.

When asked about the suggestions for us to improve in Geriatric Quiz most were silent. They were asked individually and 2 students agreed to give a reply. They said that afternoon was not the correct time to be chosen for conducting the quiz. It should have been planned in the morning. They also said that other departments should have also participated in the quiz so that Interdepartmental interactive session could have been held for the benefit of PG students.100% agreed that a post quiz lecture or debate for Pg and staff should have been held to sensitize about Geriatric Medicine. They also recommended inviting member of GSI (Geriatric Society of India), Indian gerontology Association, MCI (Medical Council of India) and RGUHS (Rajiv Gandhi University of Health Sciences) for the Quiz. The innovative online quiz method was also considered to be a good method to teach Geriatric Medicine by the students. The benefits of the online medium for delivery of this teaching and learning experience are its flexibility and Web accessibility. It has the potential to give students the freedom to access learning environments when it best suits them and in the power to control their own learning [1].

The students also felt that in the Vision 2015 report of MCI there is no mention of Geriatric Medicine as a part of MBBS curriculum [2]. If now we do not include Geriatric Medicine as a separate subject it will be far too late. In fact in every college a postgraduate course in Geriatric medicine should be started which is the need of the hour.

The mere fact of an increasing usage of MCQs by itself does not guarantee a more valid or a more reliable evaluation system although it may make it more objective. Thus we could assess the cognitive as well as psychomotor domains of the learning by the students. We gained a lot of experience from Student Feedback after the Quiz Competition.

References

1. Glassick, C. E. (1997). Scholarship assessed: Evaluation of the Professoriate. Josey Bass, San Francisco.
2. MCI Vision 2015 document Dwarka, New Delhi 2011 1-58, downloaded from www.mciindia.org/tools/announcement/MCI_booklet.pdf last accesed on 20/ April 2014.

Sagar Borker
Department of PSM, PGI-MER and
Dr RML Hospital, New-Delhi 110001.
E-mail: sagarborker@gmail.com

Guidelines for Authors

Manuscripts must be prepared in accordance with "Uniform requirements for Manuscripts submitted to Biomedical Journal" developed by international committee of medical Journal Editors.

Types of Manuscripts and Limits

Original articles: Up to 3000 words excluding references and abstract and up to 10 references.

Review articles: Up to 2500 words excluding references and abstract and up to 10 references.

Case reports: Up to 1000 words excluding references and abstract and up to 10 references.

Online Submission of the Manuscripts

Articles can also be submitted online from http://rfppl.co.in/customer_index.php.

I) First Page File: Prepare the title page, covering letter, acknowledgement, etc. using a word processor program. All information which can reveal your identity should be here. use text/rtf/doc/PDF files. Do not zip the files.

2) Article file: The main text of the article, beginning from Abstract till References (including tables) should be in this file. Do not include any information (such as acknowledgement, your name in page headers, etc.) in this file. Use text/rtf/doc/PDF files. Do not zip the files. Limit the file size to 400 Kb. Do not incorporate images in the file. If file size is large, graphs can be submitted as images separately without incorporating them in the article file to reduce the size of the file.

3) Images: Submit good quality color images. Each image should be less than 100 Kb in size. Size of the image can be reduced by decreasing the actual height and width of the images (keep up to 400 pixels or 3 inches). All image formats (jpeg, tiff, gif, bmp, png, eps etc.) are acceptable; jpeg is most suitable.

Legends: Legends for the figures/images should be included at the end of the article file.

If the manuscript is submitted online, the contributors' form and copyright transfer form has to be submitted in original with the signatures of all the contributors within two weeks from submission. Hard copies of the images (3 sets), for articles submitted online, should be sent to the journal office at the time of submission of a revised manuscript. Editorial office: Red Flower Publication Pvt. Ltd., 48/41-42, DSIDC, Pocket-II, Mayur Vihar Phase-I, Delhi – 110 091, India, Phone: 91-11-45796900, 22754205, 22756995, Fax: 91-11-22754205, E-mail: author.rfp@gmail.com, customer.rfp@gmail.com,Website: www.rfppl.co.in

Preparation of the Manuscript

The text of observational and experimental articles should be divided into sections with the headings: Introduction, Methods, Results, Discussion, References, Tables, Figures, Figure legends, and Acknowledgment. Do not make subheadings in these sections.

Title Page

The title page should carry

1) Type of manuscript (e.g. Original article, Review article, Case Report)
2) The title of the article, should be concise and informative;
3) Running title or short title not more than 50 characters;
4) The name by which each contributor is known (Last name, First name and initials of middle name), with his or her highest academic degree(s) and institutional affiliation;
5) The name of the department(s) and institution(s) to which the work should be attributed;
6) The name, address, phone numbers, facsimile numbers and e-mail address of the contributor responsible for correspondence about the manuscript; should be mentoined.
7) The total number of pages, total number of photographs and word counts separately for abstract and for the text (excluding the references and abstract);
8) Source(s) of support in the form of grants, equipment, drugs, or all of these;
9) Acknowledgement, if any; and
l0) If the manuscript was presented as part at a meeting, the organization, place, and exact date on which it was read.

Abstract Page

The second page should carry the full title of the manuscript and an abstract (of no more than 150 words for case reports, brief reports and 250 words for original articles). The abstract should be structured and state the Context (Background), Aims, Settings and Design, Methods and Materials, Statistical analysis used, Results and Conclusions. Below the abstract should provide 3 to 10 keywords.

Introduction

State the background of the study and purpose of the study and summarize the rationale for the study or observation.

Methods

The methods section should include only information that was available at the time the plan or protocol for the study was written such as study approach, design, type of sample, sample size, sampling technique, setting of the study, description of data collection tools and methods; all information obtained during the conduct of the study belongs in the Results section.

Reports of randomized clinical trials should be based on the CONSORT Statement (http://www.consort-statement. org). When reporting experiments on human subjects, indicate whether the procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional or regional) and with the Helsinki Declaration of 1975, as revised in 2000 (available at http://www.wma.net/e/policy/l 7-c_e.html).

Results

Present your results in logical sequence in the text, tables, and illustrations, giving the main or most important findings first. Do not repeat in the text all the data in the tables or illustrations; emphasize or summarize only important observations. Extra or supplementary materials and technical details can be placed in an appendix where it will be accessible but will not interrupt the flow of the text; alternatively, it can be published only in the electronic version of the journal.

Discussion

Include summary of key findings (primary outcome measures, secondary outcome measures, results as they relate to a prior hypothesis); Strengths and limitations of the study (study question, study design, data collection, analysis and interpretation); Interpretation and implications in the context of the totality of evidence (is there a systematic review to refer to, if not, could one be reasonably done here and now?, What this study adds to the available evidence, effects on patient care and health policy, possible mechanisms)? Controversies raised by this study; and Future research directions (for this particular research collaboration, underlying mechanisms, clinical research). Do not repeat in detail data or other material given in the Introduction or the Results section.

References

List references in alphabetical order. Each listed reference should be cited in text (not in alphabetic order), and each text citation should be listed in the References section. Identify references in text, tables, and legends by Arabic numerals in square bracket (e.g. [10]). Please refer to ICMJE Guidelines (http://www.nlm.nih.gov/bsd/uniform_requirements.html) for more examples.

Standard journal article

[1] Flink H, Tegelberg Å, Thörn M, Lagerlöf F. Effect of oral iron supplementation on unstimulated salivary flow rate: A randomized, double-blind, placebo-controlled trial. J Oral Pathol Med 2006; 35: 540-7.

[2] Twetman S, Axelsson S, Dahlgren H, Holm AK, Källestål C, Lagerlöf F, et al. Caries-preventive effect of fluoride toothpaste: A systematic review. Acta Odontol Scand 2003; 61: 347-55.

Article in supplement or special issue

[3] Fleischer W, Reimer K. Povidone iodine antisepsis. State of the art. Dermatology 1997; 195 Suppl 2: 3-9.

Corporate (collective) author

[4] American Academy of Periodontology. Sonic and ultrasonic scalers in periodontics. J Periodontol 2000; 71: 1792-801.

Unpublished article

[5] Garoushi S, Lassila LV, Tezvergil A, Vallittu PK. Static and fatigue compression test for particulate filler composite resin with fiber-reinforced composite substructure. Dent Mater 2006.

Personal author(s)

[6] Hosmer D, Lemeshow S. Applied logistic regression, 2nd edn. New York: Wiley-Interscience; 2000.

Chapter in book

[7] Nauntofte B, Tenovuo J, Lagerlöf F. Secretion and composition of saliva. In: Fejerskov O, Kidd EAM,

editors. Dental caries: The disease and its clinical management. Oxford: Blackwell Munksgaard; 2003. p. 7-27.

No author given

[8] World Health Organization. Oral health surveys - basic methods, 4th edn. Geneva: World Health Organization; 1997.

Reference from electronic media

[9] National Statistics Online—Trends in suicide by method in England and Wales, 1979-2001. www.statistics.gov.uk/downloads/theme_health/HSQ 20.pdf (accessed Jan 24, 2005): 7-18. Only verified references against the original documents should be cited. Authors are responsible for the accuracy and completeness of their references and for correct text citation. The number of reference should be kept limited to 20 in case of major communications and 10 for short communications.

More information about other reference types is available at www.nlm.nih.gov/bsd/uniform_requirements.html, but observes some minor deviations (no full stop after journal title, no issue or date after volume, etc).

Tables

Tables should be self-explanatory and should not duplicate textual material.

Tables with more than 10 columns and 25 rows are not acceptable.

Table numbers should be in Arabic numerals, consecutively in the order of their first citation in the text and supply a brief title for each.

Explain in footnotes all non-standard abbreviations that are used in each table.

For footnotes use the following symbols, in this sequence: *, ¶, †, ‡‡,

Illustrations (Figures)

Graphics files are welcome if supplied as Tiff, EPS, or PowerPoint files of minimum 1200x1600 pixel size. The minimum line weight for line art is 0.5 point for optimal printing.

When possible, please place symbol legends below the figure instead of to the side.

Original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay.

Type or print out legends (maximum 40 words, excluding the credit line) for illustrations using double spacing, with Arabic numerals corresponding to the illustrations.

Sending a revised manuscript

While submitting a revised manuscript, contributors are requested to include, along with single copy of the final revised manuscript, a photocopy of the revised manuscript with the changes underlined in red and copy of the comments with the point to point clarification to each comment. The manuscript number should be written on each of these documents. If the manuscript is submitted online, the contributors' form and copyright transfer form has to be submitted in original with the signatures of all the contributors within two weeks of submission. Hard copies of images should be sent to the office of the journal. There is no need to send printed manuscript for articles submitted online.

Reprints

Journal provides no free printed reprints, however a author copy is sent to the main author and additional copies are available on payment (ask to the journal office).

Copyrights

The whole of the literary matter in the journal is copyright and cannot be reproduced without the written permission.

Declaration

A declaration should be submitted stating that the manuscript represents valid work and that neither this manuscript nor one with substantially similar content under the present authorship has been published or is being considered for publication elsewhere and the authorship of this article will not be contested by any one whose name (s) is/are not listed here, and that the order of authorship as placed in the manuscript is final and accepted by the co-authors. Declarations should be signed by all the authors in the order in which they are mentioned in the original manuscript. Matters appearing in the Journal are covered by copyright but no objection will be made to their reproduction provided permission is obtained from the Editor prior to publication and due acknowledgment of the source is made.

Abbreviations

Standard abbreviations should be used and be spelt out when first used in the text. Abbreviations should not be used in the title or abstract.

Checklist

- Manuscript Title
- Covering letter: Signed by all contributors
- Previous publication/ presentations mentioned, Source of funding mentioned
- Conflicts of interest disclosed

Authors

- Middle name initials provided.
- Author for correspondence, with e-mail address provided.
- Number of contributors restricted as per the instructions.
- Identity not revealed in paper except title page (e.g.name of the institute in Methods, citing previous study as 'our study')

Presentation and Format

- Double spacing
- Margins 2.5 cm from all four sides
- Title page contains all the desired information. Running title provided (not more than 50 characters)
- Abstract page contains the full title of the manuscript
- Abstract provided: Structured abstract provided for an original article.
- Key words provided (three or more)
- Introduction of 75-100 words
- Headings in title case (not ALL CAPITALS). References cited in square brackets
- References according to the journal's instructions

Language and grammar

- Uniformly American English
- Abbreviations spelt out in full for the first time. Numerals from 1 to l0 spelt out
- Numerals at the beginning of the sentence spelt out

Tables and figures

- No repetition of data in tables and graphs and in text.
- Actual numbers from which graphs drawn, provided.
- Figures necessary and of good quality (color)
- Table and figure numbers in Arabic letters (not Roman).
- Labels pasted on back of the photographs (no names written)
- Figure legends provided (not more than 40 words)
- Patients' privacy maintained, (if not permission taken)
- Credit note for borrowed figures/tables provided
- Manuscript provided on a CDROM (with double spacing)

Submitting the Manuscript

- Is the journal editor's contact information current?
- Is the cover letter included with the manuscript? Does the letter:

1. Include the author's postal address, e-mail address, telephone number, and fax number for future correspondence?
2. State that the manuscript is original, not previously published, and not under concurrent consideration elsewhere?
3. Inform the journal editor of the existence of any similar published manuscripts written by the author?
4. Mention any supplemental material you are submitting for the online version of your article. Contributors' Form (to be modified as applicable and one signed copy attached with the manuscript)