

Table 3: Correlates of Functional Impairments: Multiple Logistic Regression Analysis

Correlates of Functional Impairments	Category	OR (adjusted)	95% C.I.	p-value
Gender	(a) Male	1.00	-	-
	(b) Female	0.87	0.21-3.60	0.851
Age Group(years)	(a) 65-69	1.00	-	-
	(b) 70-74	2.60	1.65-10.43	0.182
	(c) ≥75	10.47	1.78-21.01	0.009*
Financial Dependence	(a) Totally Independent	1.00	-	-
	(b) Partial	2.28	0.34-15.37	0.406
	(c) Totally dependent	2.61	0.28-24.50	0.410
Marital Status	(a) Married	1.00	-	-
	(b) Single (Unmarried/ Widowed/ Separated)	0.76	0.14-4.04	0.751
Living Arrangement in Household	(a) With spouse	1.00	-	-
	(b) With children & relatives	1.70	0.22-13.39	0.618
	(c) Alone	1.24	0.89-17.24	0.872
Literacy Status	(a) Literate	1.00	-	-
	(b) Illiterate	0.23	0.05-1.02	0.054
H/o Death in the Family within last 6months	(a) Absent	1.00	-	-
	(b) Present	9.81	1.22-16.73	0.023*
H/o Accidents in last 5 years	(a) Absent	1.00	-	-
	(b) Present	8.16	2.28-18.42	0.012*
Presence of Chronic Illnesses	(a) 0-2	1.00	-	-
	(b) ≥3	16.3	1.23-13.47	0.001*

* p value <0.05 was considered as significant

illnesses were independently associated with functional impairments in elderly individuals.

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Flupirtine

DRUG PROFILE

Indication: Flupirtine is a centrally acting non-narcotic analgesic with N-methyl-D- aspartate (NMDA) receptor antagonist property which has been shown to be effective in the management of postoperative and other painful conditions in which the primary requirement is analgesia without sedation or anti-inflammatory effects. **Chemistry:** Is a derivative of triaminopyridine is available as the maleate salt. **Pharmacodynamic Effect:** the spectrum of action of Flupirtine Include analgesia, muscle relaxation and neuroprotection; this drugs is neuroprotective, antiepileptic and antiparkinsonism and does not appear to interact directly with adrenoreceptors, dopaminergic receptors benzodiazepine receptors, nicotinic receptors or 5-HT receptors. **Pharmacokinetics:** Flupirtinemaleate is freely soluble in water and undergoes rapid gastric absorption appear in the plasma within 15-30 minutes resulting in peak plasma concentrations (Cmax) of approximately 0.8 and 2.0mg/l at 1.6 to 2 hours (Tmax) post dose. Bioavailability in comparison with an intravenous dose of flupirtine tartrate 80mg was 100% for the oral dose and 72.5% for the rectal dose. Over a plasma concentration range of 0.05 to 2.0mg/L, flupirtine was 94% bound to plasma proteins in the rat and 0 to 84% reversibly bound to human albumin. Flupirtine, whether administered orally or rectally, undergoes biotransformation in the liver to two primary metabolites, p-fluoro-hippuric acid an acetylated metabolite which has 20 to 30% of the analgesic activity of the parent compound clearance in healthy volunteers was 16.5 L/h, 72% was excreted in the urine, 18% was excreted in the feces, half-life of flupirtine following intravenous administration was 1.8 hours, oral and rectal routes was 8.5, 9.6 and 10.7 hours, respectively, decrease in the initial dose of flupirtine, possibly accompanied by increase in dose interval, would appear prudent in elderly patients. Recommendations for dose adjustment in elderly patients should also apply to patients with mild degrees of renal impairment. Flupirtine should be administered cautiously in patients with hepatic disease, especially those with primary biliary cirrhosis and/or a history of encephalopathy.