

supplementation clinical trials have inadequacies, importantly inclusion of subjects who do not have low vitamin D status and failure to recognize individual 25(OH)D response to vitamin D supplementation.

These issues highlight the changes to conducting meta-analyses with unstandardized 25(OH)D data and inclusion of subjects who could not have a positive response to additional vitamin D. As such, it is suggested that additional vitamin D-related meta-analyses not be published at this time. These examples underscore the challenges (perhaps impossibility) of developing rationale vitamin D guidelines at this time. Given this uncertainty, it is suggested that highly sun exposed individuals be used to guide determination of the target 25(OH)D level. Taking this approach identifies "normal" vitamin D status as a 25(OH)D of ~ 100 nmol/L; supplementation to achieve this level is reasonable.

## **DYSMOBILITY SYNDROME: THE FUTURE OF FRACTURE RISK REDUCTION**

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Falls and fractures increase with age, and adversely impact independence and well-being of older adults. Both sarcopenia and osteoporosis contribute to falls/fracture risk; because of this, the term osteosarcopenia has been suggested. However, other factors, e. g., obesity, is also a risk factor for falls and fractures. As such, even osteosarcopenia is not adequately inclusive of a term. Indeed, rather than focusing on each condition individually, an opportunity exists to combine clinical factors to potentially improve identification of older adults at risk for falls and fractures. Our group has termed such a combination "dysmobility syndrome". Within such a conceptual framework, dysmobility syndrome becomes analogous to metabolic syndrome, i. e., a group of conditions that lead to increased risk for adverse health outcomes; vascular disease for metabolic syndrome, falls/fractures for dysmobility syndrome. To summarize, "osteoporosis-related" fractures are not solely due to osteoporosis, but rather the result of a complex geriatric syndrome with multiple inputs (e. g., sarcopenia, osteoporosis, obesity, diabetes, etc.) Whether this syndrome ultimately comes to be called dysmobility syndrome is irrelevant; it is the concept that is important. Reducing fracture risk, and thereby maintaining independence and quality of life for older adults, requires focus on the entire individual, not simply the parts. Such an approach is certainly the future of "osteoporosis" care. There is no reason that today's knowledge cannot or should not be applied now.

## **RISK FACTORS FOR RESPIRATORY DISEASES IN ELDERLY**

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The number of elderly (> 65 years) is constantly growing worldwide. Within the morbidity structure, respiratory diseases among elderly people are third in terms of its frequency after cardiovascular and nervous system diseases. During the last 10 years, among the reasons for total disability and death, the respiratory pathology continues to grow in the Republic of Kazakhstan. According to the statistics agency the number of deaths from respiratory diseases in Kazakhstan in 2011 increased and was 8.6 thousand people, the mortality rate was 52.1 per 100 thousand people.

**Aim.** To study the prevalence of smoking and associated respiratory diseases in the elderly.

**Subjects and Methods.** Altogether 400 residents of Kegen village of Almaty region aged from 65 years and older examined by questioning.

**Results.** The frequency of the main risk factor for respiratory diseases, tobacco smoking, was 16 % of the total examined. The highest percentage of smokers was diagnosed mainly among men. About 80 % had a history of previous marked respiratory diseases (chronic bronchitis, pneumonia, pleurisy).

**Conclusion.** Smoking, previous diseases and aging of the respiratory system are the risk factors for respiratory diseases in the elderly leading to the disturbance of respiratory function in the form of restrictive and obstructive disorders.