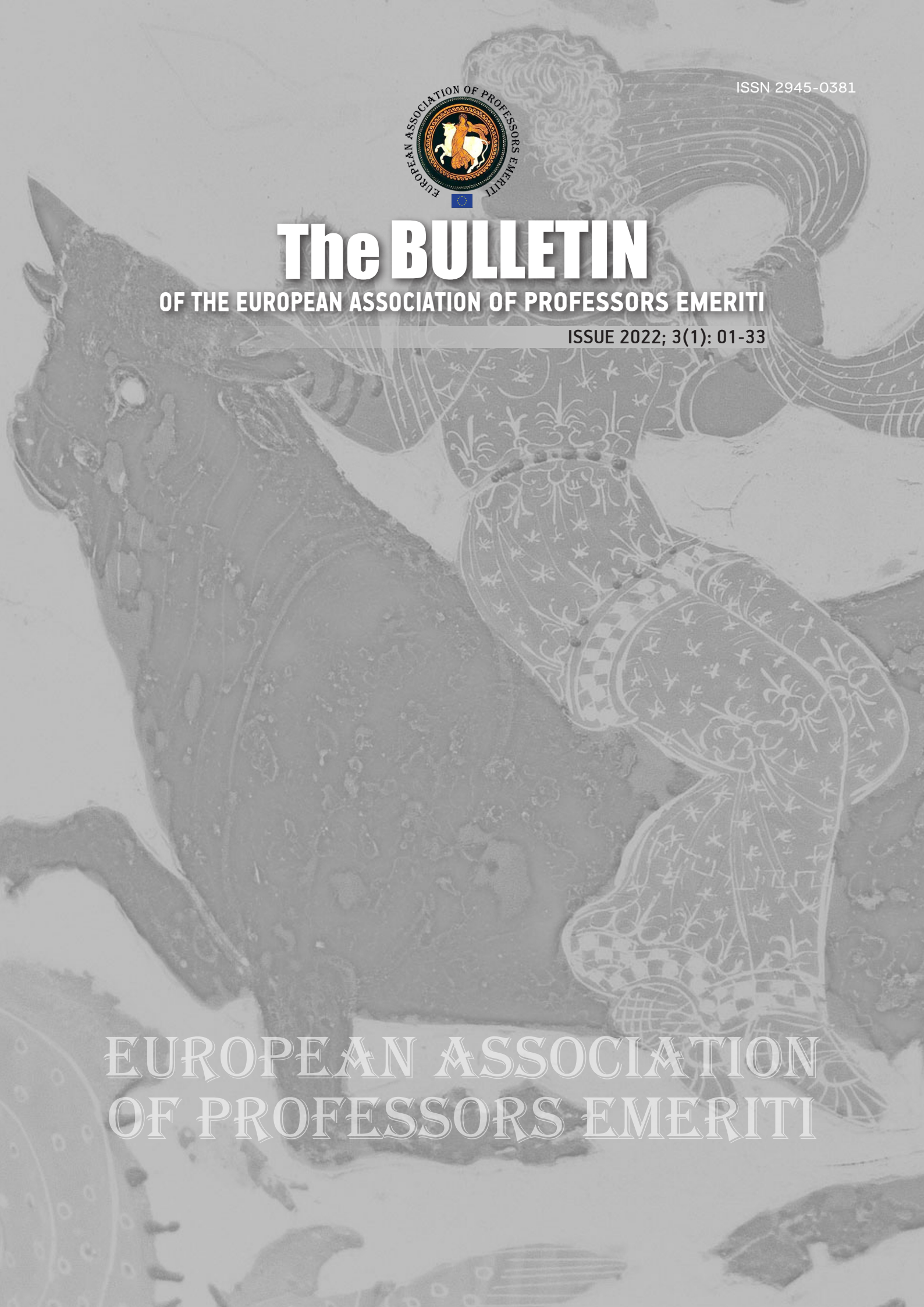
ISSN 2945-0381

The BULLETIN

OF THE EUROPEAN ASSOCIATION OF PROFESSORS EMERITI

ISSUE 2022; 3(1): 01-33



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The Bulletin
of the European Association of Professors Emeriti

Bull Eur Assoc Profs Emer - Bimonthly Distribution (6 Issues per Year)

PUBLISHER

The European Association of Professors Emeriti
8, Christou Lada Street, 10561 Athens, Greece
VAT: 997074687

ISSN 2945-0381

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Don't Die of Ignorance!

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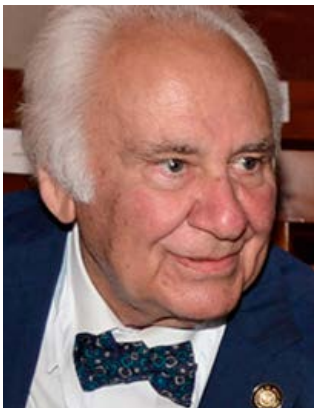

Natale Gaspare De Santo

editorial

The peculiarity of the physician's job

Hans George Gadamer, the Philosopher of Hermeneutic, supported the notion of the "peculiarity of a physician's job". A job which in the collective imaginary is more like that of an artist than that of a scientist or an artisan. "The peculiarity of the physician's job depends on his work with patients. The presence of the physician at a difference with the artisan does not produce anything, even when we consider that the work of the physician is all centred on the patient" (*The Enigma of Health: The Art of Healing in a Scientific Age,* 1996).

In the middle of the 1980's the walls of the metro in London were covered by posters in bright colours against a black background, with the message: "*Don't die of ignorance!*" It was Margaret Thatcher's campaign against AIDS: the virus was known, the modality of contagion too, as was the modality to escape it. But there was opposition to adopt those measures just as today for Covid-19 vaccines.

Health systems are unjust and collapse

Health protection is a costly procedure since the present model is based on cures. A pill for every disease, the dream of Paul Ehrlich (1854-1915). Health systems worldwide tend to collapse, because of their increasing costs, thus they have been put in the hands of managers who have levelled resources and expenditures by reducing the quantity and quality of services provided. This was the end effect of the advent of managed care, a by-product of the up-rush of the economy in all aspects of human life. This has generated healthcare systems that are unjust. In fact, rich people live longer than poor people.

I like to remember that, in UK from the postmark one learns that children born in poor regions of the country live up to 11 years less. In Turin, Italy, those who live on the mythical hill, where the Family Agnelli lives, have a life expectancy which is four years longer than the people living in popular quarters (G. Padovani, *Il diritto negato*, *La salute e le cure sono uguali per tutti?* 2008). In Naples life expectancy at birth is 3.5 years below the average for the country. According to Sir Michael Marmot, FBA, FMedSci, FRCP Professor of Epidemiology and Public Health at University College of London, along the Washington subway - from the poor quarters in the south-east of the city, where black people live, to the rich county of Montgomery, where rich people live - for every mile the length of life of the inhabitants increases by 18 months; resulting, in total, at the extremities of the underground, of about 20 years difference in life expectancy. In other words, according to the quarter where one lives and according to the economic and cultural resources, life expectancy varies from 53-58 years up to 73-78.

Prevention is better than cure

As written by Nobel Luc Montagnier and Dominique Vialard (*Les combats de la vie: mieux que guérir, prévenir,* 2007) "20% of the patients use 80% of the resources. In the long run there is only one possible way, both for society and the single individual. We need to act on *causes* of diseases promoting a policy of prevention. Nowadays we invest only 2% of the health care budget on prevention. We have to act on risk factors and the causes of diseases. Some factors are environmental and cannot be abolished unless we plan collective actions on a planetary scale. For example the particles dispersed in the air. We need a new science aiming to slow the course of a serious disease or to prevent it. This might well represent the profile of a health strategy where medicine, instead of taking care of near-invaliding, lethal cases – a disaster also for society – plays the role of prevention". The reasons are to be found in the inadequate development of clinical research and having failed to understand that protecting health is an opportunity, a motor for economic growth.

"If we really want to transform the quality and safety of healthcare, we can't just do more of what we do now. Even doing it more efficiently won't be enough" —wrote Fiona Godlee, resigning editor of the British *Medical Journal* at the end of 2021— "We have to do different things and we have to do things differently. Put the patients at the centre of things. Let the System again fit the patient, stop the tradition of the patients fitting the System".

Physicians promoted in Florence, in 1451, the first guild and kept it strong until the 20th century. A strong guild, now in its declining stages. There is a great loss of autonomy in the medical profession (Krause EA, *Death of the Guilds*, 1996).

Furthermore—as stated in 1997 by Thomas Haskell in *The New Aristocracy*— "Nowadays, health providers decide who must be cured and for how long. Today, those who hire and fire physicians impose the choice of means allowed to be utilized in curing patients. In fact, the managed care is economically successful if one does only a minimum for patients. This is true and we do know that the quality of care is reduced by the necessity to contain costs".

From dealing with disease to maintain wellness

As pointed out by Leroy Hood "medicine is changing from traditional reactive mode, in which doctors wait for people to get sick, to a mode that is far more preventive and rational. It is called P4 medicine: predictive, personalized, preventive and participatory. The focus of medicine is placed on individual patients. The focus of healthcare shifts from dealing with disease to maintain wellness" (1).

Research also changes and medical education will also need to be transformed.

We need to promote clinical research. Without basic research everything collapses, including economy. But without clinical research, very little trickles down to patients and their expectations for cures and quality of life. Clinical research is the Cinderella for what attains to funding. Today a few discoveries in basic biomedical research get turned into treatments and cures. "Scientists call the gulf between a biomedical discovery and the development of a drug, *valley of death*". Taxpayers have already paid for the basic discovery (2).

The medical-industrial complex

I take the opportunity to remember another impending problem discussed for nearly 30 years by Arnold S Relman, Editor in chief of the New *England Journal of Medicine* in the years 1977-1991. "The most important healthcare development of the day is the recent, relatively unheralded rise of a huge new industry that supplies healthcare services for profit. Proprietary hospitals and nursing homes, diagnostic laboratories, home-care and emergency-room services, hemodialysis, and a wide variety of other services produced a gross income to this industry last year of about $35 to $40 billion. This new "medical-industrial complex" may be more efficient than its non-profit competitor, but it creates the problems of overuse and fragmentation of services, overemphasis on technology, and "cream-skimming," and it may also exercise undue influence on national health policy. In this medical market, physicians must act as discerning purchasing agents for their patients and therefore should have no conflicting financial interests. Closer attention from the public and the profession, and careful study, are necessary to ensure that the "medical-industrial complex puts the interests of the public before those of its stockholders" (3). The disasters of the medical-industrial complex were well illustrated by Michael Moore, in *Sicko* (2007) a political documentary film.

"The monster is like the mythical hydra, with many heads. And we shall abate the hydra said Robert M. McLean, President of the American College of Physicians in the presidential message in *ACP-Internist*, in April 2020 (4).

Theory of Epidemiological Transition

A lot can be learned from evolution, from the *Theory of Epidemiological Transition* (5) of Abdel R. Omran and its stages ("famine, receding pandemics and of degenerative diseases and man-made disease"). The theory has been adjourned frequently, and finally poverty (initially neglected) has been taken into consideration along with incomes. It has been shown that rich and educated people are not at variance from poor non-educated people in adopting intemperate lifestyles causing non-communicable diseases associated with morbidity and mortality. However rich, educated people when made aware of the risk connected with those diseases accept modification of their lifestyles, whereas poor non-educated people will not. Thus, the latter group will experience morbidity and mortality of the disease (third transition phase) at the time when rich, well-educated people have achieved protection.

In conclusion: (i) Clinical research and prevention are fundamental elements of sustainable healthcare systems based on patient' needs (6); (ii) Progress in science is of value only if it is of benefit to the whole of mankind; (iii) Science will rescue us, however; (iv) Preventions is better than cure; (v) People still die of ignorance.

Acknowledgements. This material was part of the Salutation to the 1st Meeting of the Committee for Health promotion and Prevention of the European Association of Professors Emeriti, on December 1, 2021.

1. Hood L. *A doctor's vision of the future of medicine*. Newsweek, 2009; June 27, pp. 47-52.

2. Relman AS. *The New-Medical-Industrial Complex*. N Engl J. Med 1980; 303: 963-969.

3. McLean R.M. *Battling the hydra of the medical-industrial complex - ACP Internist, https://acpinternist.org accessed November 30, 2021.*

4. Omran A R. The epidemiologic transition. A theory of the Epidemiology of Population Change, Milbank Memorial Fund Quarterly 1971; 49(4). 509-538.

5. Pearson Th. A. *Education and income: double-edged swords in the epidemiologic transition of cardiovascular diseases.* Ethnicity & Disease 2003, 13: S2158-S2-163.

6. De Santo NG, Perna AF, Cirillo M. *Clinical reserch and prevention: fundamental elements of sustainable health care systems based on patients' needs*. Ital J Public Health 2011; 8: 89-108.

Robert William Schrier (1936-2021)
A World Leader in Renal Medicine
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Dr Malcolm Phillips

Robert Schrier-Bob- was born in Indianapolis in 1936. His mother was a nurse, his father, a printer who died when Bob was 3 years old. He had a glittering career in Medicine becoming a world leader in Nephrology. He was universally liked and respected. He died in January 2021, leaving a wife, 4 children, 13 grandchildren and 2 great-grandchildren.

Early Days

His college education started in Indianapolis at De Pauw University where, in 1957, he received his Batchelors Degree. There he met Barbara, his wife to be-a marriage, in 1959, which lasted almost 62 years. In 1957 he won a Fulbright Scholarship which took him to Johannes Gutenberg University, Mainz, Germany.

From school age he was recognised as a talented basketball and baseball player. Such was his involvement in these sports that he admits, in his Memoirs (1), he managed to fit in a game of baseball on his wedding day. He recited his vows on time- but it was a very close call! He considered a career in basketball but, happily for the world of Medicine, chose to go to Indiana University Medical School. He graduated MD in 1962.

His first medical position was at Marion County General Hospital, followed by 2 years residency at the University of Washington, School of Medicine, Seattle. This was followed, in 1965, by a Fellowship at Harvard at the Peter Bent Brigham Hospital where his research was in Endocrinology and Metabolism. This was the start of what became his lifelong interest-the renal regulation of salt and water. In 1966 he entered the army, working at the Walter Reed Hospital and the Army Institute of Research. That year he met Hugh de Wardener, Professor of Medicine, Charing Cross Hospital, London, who invited him to work with him on the renal mechanisms of sodium transport. Bob travelled to London in 1967. After 10 months he returned to USA to complete military service.

Professorial Roles

In 1969 he became Assistant and later, Associate Professor of Nephrology at the University of California, San Francisco. In 1972 he moved to the University of Colorado, Denver as Head of the Division of Renal Diseases and Hypertension. This was the start of a development programme which, over the next 30 years, achieved enormous success. He promoted training of Fellows in renal medicine and research. He was especially involved in the mentorship of Fellows-ultimately over 200 passed through his department.

His research work extended beyond nephrology into cardiology, liver disease and pregnancy. A Spanish hepatologist described Schrier as "one of the greatest nephrologists of all time" (2) noting Bob's findings that in cirrhosis, fluid retention related to under-filling of the arterial circulation secondary to increases in vasodilators, especially nitric oxide. This led to the now standard treatment for the condition called the Hepato-Renal Syndrome (3).

In 1976 he became Chair of Medicine, a post he held for 26 years-the longest-serving chairman of a Division of Medicine in the USA. He built up the faculty membership from 75 to over 500, and increased annual research funding from $3 million to nearly $100. He attracted uninterrupted, competitive funding from the National Institutes of Health for 45 years and generated endowments for 30 chairs in various branches of Medicine. His sectional heads were highly qualified specialists in areas including respirology, cardiology, oncology, haematology and internal medicine.

1. *Life's Lessons Learned: My Memoirs,* Schrier R W. 2014. Pub: Create Space Independent Publishing Platform USA.

2. *Robert W Schrier: an influential observer from outside Hepatology* (Obit). Gines P. 2021. J Hepatol 74,1281-1282.

3. *Renal Failure in Cirrhosis* Gines P, Schrier R W. 2008. New Engl J Med Sep 24, 361 (13), 1279-1290.

Beyond these achievements he maintained a very active research profile, took part regularly in clinical Nephrology, and was always a dedicated family man. He developed training programmes for medical students, junior doctors and researchers. His home was regularly the site for mentoring these people at weekends.

In his lifetime Bob published over 1000 scientific papers and edited, authored or co-authored over 50 books. Of note were some of the most-referred-to books on Nephrology, especially his giant reference book "Diseases of the Kidney and Urinary Tract", recognised as the most comprehensive textbook of its kind ever published.

Robert William Schrier

Medical Societies/ The International Society of Nephrology

Given his medical and scientific status, not surprisingly, Bob was a member of many societies. At varying times, he was President of the Association of American Physicians, the American Society of Nephrology, the National Kidney Foundation and the International Society of Nephrology (ISN, 1995-97). He was elected to the National Academy of Medicine in 1989, made an Honorary Fellow of the Royal College of Physicians UK in 1998, and Honorary Member or Professor of the societies of nephrology of South Africa, Paris, Germany, Beijing, Africa, Poland, Thailand, Columbia and Slovakia.

During his long period with the ISN he promoted global development of nephrology. He launched the ISN Fellowship Program whereby physicians in under-developed countries were sponsored to train in nephrology for 2 years at established renal centres; over 600 doctors passed through this programme, most returning to their own countries to care for renal patients and teach others. He developed the Sister Renal Centers Program which links developing kidney units with established units. By 2014 there were over 50 pairings worldwide; the most productive receive the Robert W Schrier Award at ISN World Congresses.

Post-Retirement

"Retirement" is an inappropriate term in relation to Bob Schrier. After 2002 Bob's main academic activity related to Autosomal Polycystic Kidney Disease (APKD)-an inherited disorder accounting for about 10% of patients on long-term dialysis. He continued to research mechanisms of salt and water retention in heart failure, liver disease, kidney disease and pregnancy. His long-term interest in fluid balance, oedema, hyponatraemia continued, along with other renal disorders. Diabetes mellitus-another major cause of kidney failure-also featured strongly in his research. He continued active mentorship and, aged 75 years, this was recognised with a major award for Academic Mentorship.

Between 2003 and 2018 he had 177 publications relating to APKD (63 papers), fluid balance (44), fluid retention in heart failure, cirrhosis and pregnancy (18) and diabetes (16).

Outside of medicine he pursued an interest in American history writing and lecturing on the political and medical events in the lives of 20th century US Presidents (4), and, separately, about the lives of famous world leaders-Lincoln, Gandhi, Mandela and Luther King (5). A later book was his Memoirs, entitled "Life's Lessons Learned" (1).

In 2012 at the age of 76 he became Professor Emeritus, University of Colorado School of Medicine.

Some Quotes

Bob - one of his favourite quotes was from George Bernard Shaw: "Some men see things as they are and ask 'Why?'. Others dream of things that never were and ask 'Why not?'"

Thomas Berl—Bob's successor at Colorado: "His most enduring legacy may be his commitment to mentor the large number of fellows and scientists who spent from weeks to years in his research programme" (6).

Bob, on his wife Barbara— "Her legacy, as leader of our family, dwarfs anything that I have ever done" (1).

Barbara on Bob—after his passing: "Bob sought the best in others and gave the best he had" (6).

Bob Schrier: sportsman, doctor, researcher, leader, husband, father. A giant, physically, medically and academically. His roles, into old age, in many fields, perhaps especially his achievement in passing on his knowledge and wisdom to younger colleagues and his family, is a major tenet of this organisation both in relation to careers and life in general. He perhaps merits honorary membership of the EAPE, albeit posthumously.

4. *Profiles of American Presidents in the Twentieth Century: Merits and Maladies,* Schrier R W. 2011. Pub: Create Space Independent Publishing Platform USA.

5. *Moral Courage: Abraham Lincoln, Mahatma Ghandi, Nelson Mandela, Martin Luther King Jr,* Schrier R W 2012. Pub: Create Space Independent Publishing Platform USA.

6. *In Memoriam: Robert W Schrier 1936-2021,* Berl T, Linas S. 2021. Kid Intl 99, 1042-1044

World Travel by Old People: Healthy Leisure or Risky Lifestyle?

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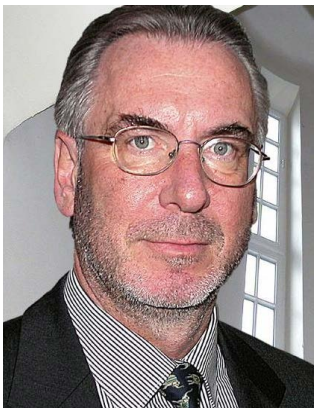

Gerd Burchard

Wealthy people are "world champions" at travelling: further and further, more and more exotic, more and more often. Old people also like to be "world champions"! This creates a high social pressure and sportive competition "to keep the title of a champion". A trend towards long-distance travel and an enthusiasm for active and adventurous travel can be observed in the search for new vacation destinations and forms (Table 1). As enriching or relaxing as these long-distance trips may be, they can also pose risks for the old generation (Table 2).

Chances and risks of travel

Seniors often go on longer trips - they want to enjoy the fruits of years of work, usually in warmer climes than at home and often as "overwinterers", or they want to get to know foreign cultures. Medical travel advice has the task of providing intensive advice to healthy seniors to allow a healthy return. Older travellers with previous illnesses in need of treatment must be helped to prevent worsening of existing illnesses during or after the trip. Polypharmacy and underlying chronic disorders, e.g., cardiovascular disease, diabetes mellitus and chronic respiratory diseases are risk factors. The GeoSentinel Surveillance Network published data relating to patients aged 60 years and above and compared them with a younger adult reference population (1). They identified higher proportionate morbidity among older travellers in lower respiratory and urinary tract infections, pulmonary edema at high altitude, pulmonary embolism, insect bites, severe malaria, rickettsial infections, gastric ulcers, gastroesophageal reflux, cardiovascular disease and trauma. Travel diarrhea is one of the most common health disorders when traveling. In older people, the production of stomach acid and thus the protection against diarrhea pathogens decreases. Older travellers can experience serious water and electrolyte imbalances more quickly than younger adult travelers. Older travellers should therefore be given particularly thorough information on the symptomatic measures to be taken in the event of travellers' diarrhea.

Table 1. Current trends in travel and vacations
1. More people are travelling.
2. Destinations are becoming more exotic.
3. Travellers are getting younger and older.
4. Travel content is becoming more spectacular. «Risky life-styles,» mean not only recreation, but rather a distinct physical and mental strain.
5. The majority of tourists follow the trends of fashion in their travel activities, so-called «ant trails», which are characterized by a health risk that can be well calculable before the start of the trip.
6. Striving for normality and autonomy of chronically ill people and possibilities of global prevention and therapy of serious chronic illnesses allow for an enhanced travel activity for this group.
7. Despite improved hygiene measures in many places in the world, the risk of infection remains high when travelling.
8. The range of travel medicine advice on offer has broadened. Advice is provided not only by individual general practitioners and tropical institutes but also by specific travel advisory centres. Advice is also provided by internet, telephone or through appropriate literature.
9. The cost of travel medicine-guided prevention through vaccination and chemoprevention has increased and is not covered by health insurance but by the travellers themselves.
10. Despite increased activities of the media to draw attention to travel illnesses, there has been no significant change in the attitudes of travellers. Travellers seeking medical advice beforehand and following it can be differentiated from travellers who seek medical advice in advance but do not follow all recommendations and guidelines, and lastly from travellers who neither seek medical advice nor take prophylaxis

1. Gautret P, Gaudart J, Leder K, et al , GeoSentinel Surveillance Network (2012) J Travel Med doi: 10.1111/j.1708-8305.2012.00613.x.

Table 2. Travel diseases
1. Heat and cold illnesses including isolation, sun stroke, electrolyte and water loss, sunburn, photo-dermatoses, hypothermia, frostbite.
2. Altitude sickness.
3. Motion sickness.
4. Infections.
5. Intoxications, stings, bites.
6. Ectoparasitoses.
7. Accidents (traffic accidents, falls).

Recommendations for prophylaxis

Immunosenescence can shorten the duration and reduce the strength of the vaccination response. This applies, above all, to the first vaccination with a pathogen unknown to the immune system and is less pronounced than with a booster vaccination. Older travelers can particularly benefit from vaccinations against pneumococcal disease and influenza. In the case of inactivated vaccines, these are normally well tolerated. However, the effectiveness and the duration of the effectiveness can be limited. If, in addition to age, there are risk factors such as an immunosuppressive disorder, serological controls can provide information on the respective protection status in individual cases. With live vaccines such as the yellow fever vaccine, some studies found an increased risk of serious adverse reactions after administration to people >60 years of age. The most feared adverse reaction is yellow fever-associated visceral disease which can be fatal.

Malaria still is a relevant problem in many tropical and subtropical countries. It can be assumed that complications in falciparum malaria (including cerebral and renal damage as well as acute respiratory distress) occur more quickly if there are already functional deficits. The mortality in falciparum malaria is therefore higher in older patients. Accordingly, the recommendations on malaria prophylaxis for older travellers are particularly important. The main goal of malaria prophylaxis is to prevent morbidity and mortality from falciparum malaria. In selecting an appropriate medication for chemoprophylaxis or treatment of malaria it becomes more difficult as older adults undergo physiologic changes that alter the pharmacokinetic and pharmacodynamic nature of medications potentially causing increased drug interactions, adverse events and altered drug action (2).

2. Lewis J, Gregorian T, Portillo I, Goad J (2020) Drug interactions with antimalarial medications in older travellers: a clinical guide. J Travel Med https://doi.org/10.1093/jtm/taz089

Chronic Kidney Disease: A Human Model of Accelerated Aging

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Chronic Kidney Disease (CKD) is a healthcare problem, that can be easily compared to diabetes for its scope, impact, and consequences on well-being. About 10 % of the general population is affected by CKD, and it represents, by itself, the sixth cause of death.

CKD is a syndrome delineated as alterations in kidney function and/or structure lasting more than 3 months, characterized by loss of nephrons and renal fibrosis. To classify CKD, glomerular filtration rate (GFR) and albuminuria must be used, since GFR is regarded as a marker of excretory function and albuminuria is an indicator of glomerular injury. Identifying the cause is important: diabetes and hypertension are the most common, but there are many other causes, such as polycystic kidney disease, glomerulonephritis, etc. There are also several contributing risk factors, for example gender, obesity, use of anti-inflammatory drugs, low birth weight, congenital abnormalities of the urinary tract, infections, etc. Although the prevalence of CKD is higher in women than in men, men are more likely to progress to advanced stages.

This disease has a tendency to worsen, to progress. Glomerular hyperfiltration and hypertension occur as a physiological response to nephron loss; however, this compensatory mechanism, with time, frequently backfires, and in fact excessive intraglomerular shear stress causes podocyte detachment and more interstitial fibrosis.

To diagnose CKD, it is necessary to obtain initially blood creatinine, urea and electrolyte levels, a urinalysis, and abdominal ultrasound. In addition, there are steps to be taken addressing the cause of CKD. For example, if glomerulonephritis is suspected, a kidney biopsy may be necessary, and once proven, immunosuppressant drugs may be utilized. Other diseases liable to causal therapy in recent years are polycystic kidney disease, Fabry's disease, and atypical uremic hemolytic syndrome. The field of so-called "rare diseases", diseases with a low prevalence, but high complexity, such as tubulopathies, cystinuria, Bardet-Biedel disease, is also blooming, as knowledge increases. Onconephrology is another subspecialty gaining momentum as more and more people have access to oncological therapies. Furthermore, of paramount importance there is blood pressure control, as well as management of proteinuria with angiotensin converting enzyme inhibitors or angiotensin-II receptor antagonists ("sartans").

Recently, sodium glucose cotransporters (SGLT2) inhibitors, also called gliflozins, are available, drugs proven in randomized clinical trials to retard the progression of renal failure. Considering the stage, it could also be very useful to utilize low protein diets (the Neapolitan school was one of the first in the world to propose this therapy), erythropoietin, iron, various vitamins, etc. CKD is easily complicated by several issues: 1) anemia, due to accumulation of uremic toxins and relative erythropoietin deficiency, impacting on one's sense of well-being and quality of life; 2) the so-called CKD-Mineral and Bone Disorder (CKD-MBD). CKD-MBD determines a negative influence on progression, and the deposition of calcium salts in blood vessels causes an increase in cardiovascular events. Several drugs can be of help, such as phosphate binders, vitamin D, and calcimimetics; 3) metabolic acidosis, hyperkalemia, hyperuricemia, dyslipidemia, etc. Most of these complications are due to "uremic toxicity", the accumulation of uremic toxins referred to above. Uremic toxins are numerous and varied in relation to their physicochemical properties, molecular weight and protein-binding, and their origin, for example diet, metabolism, and gut microbiota.

Renal replacement therapy is necessary when the body can no longer cope with the excretory and homeostatic demands of our metabolism, and is represented by transplantation, peritoneal dialysis, and hemodialysis (1).

CKD can be considered a "model" of accelerated aging under many respects, an aspect which is linked to uremic toxicity. In fact, in CKD we have this premature aging phenotype, characterized by low grade chronic inflammation, sarcopenia, osteoporosis, frailty, and the mentioned extremely high cardiovascular mortality. In particular, early vascular aging is quite characteristic of CKD, sustained by vascular calcification, microinflammation, DNA damage, epigenetic alterations, gut dysbiosis, and is a hallmark of senescence.

Aging, contrary to common perception, is not a process intervening in the last stages of life, but one that occurs slowly during the entire lifetime, and characterized by the accumulation of various types of damage (2). The exposome, that is the hits we receive during our life just by living (through eating, exercise, psychological stress, etc) plus our genetic blueprint lead to the accumulation of physiological and molecular deficits and therefore physiological frailty and loss of resilience (2). In CKD, however, many uremic toxins, not normally present at all in the absence of this condition, are increased, sometimes in very high concentration, such as p-cresyl sulfate, indoxyl sulfate, homocysteine, lanthionine, just to name a few.

For example, we have shown that DNA methylation, an important epigenetic regulatory mechanism, is lower in CKD, and this is a consequence of the accumulation of homocysteine, a cardiovascular risk factor, and of its precursor S-adenosylhomocysteine, a known methylation inhibitor (3). DNA hypomethylation is typical of the aging process. Another aspect of this complex and deranged sulfur metabolism is related to the levels of hydrogen sulfide, H_2S, a gasotransmitter with many biological properties, in CKD. H_2S is a powerful modulator of healthspan, severity of disease, and longevity, and we have demonstrated that H_2S is significantly lower in CKD.

Others have shown that in the CKD-MBD pathogenesis, the Fibroblast Growth Factor23(FGF23)-α-Klotho axis is altered, with low levels of α-Klotho and increased FGF23. α-Klotho converts the FGF receptor in its high affinity form towards its ligand, FGF23. When α-Klotho is low, as in uremia, this effect is lost. Membrane α-Klotho shedding yields its circulating form, which acts as a hormone by modulating several functions, such as the intracellular insulin/IGF-1

1. Romagnani P, Remuzzi G, Glassock R, Levin A, Jager KJ, et al. Chronic kidney disease. Nature Reviews Primers, 2016:17088 doi:10.1038/nrdp.2017.88.

2. Salvatore F. The shift of the paradigm between ageing and diseases. Clin Chem Lab Med, 2020, doi.org/10.1515/cclm-2020-0125.

3. Ingrosso D, Cimmino A, Alessandra F Perna AF, Masella L, De Santo NG, et al. Folate treatment and unbalanced methylation and changes of allelic expression induced by hyperhomocysteinaemia in patients with uraemia. Lancet, 2003: 361(9370):1693-9.

signaling cascade. This activity likely contributes to the antiaging effects of α-Klotho because inhibition of insulin-like signaling is an evolutionarily conserved mechanism for extending life span.

Telomere attrition, mitochondrial dysfunction, stem cell exhaustion, and other markers of aging are present in CKD. H_2S, Klotho, nuclear factor erythroid 2-related factor 2, vitamin K, folates, the methylome and epigenome, the p53 pathway, senescent cells, etc represent all interesting potential targets of senotherapies. How to intervene on these processes represents the emerging field of Geroscience, with the aim of addressing the molecular and cellular mechanisms of aging and of aging in CKD, through the use of senolytic agents, for example, or other more conventional tools (exercise, nutrition, gut microbiota interventions, drugs, dialysis), acting therefore at different levels (4). Undoubtedly, this field holds in store many exciting innovations in the near future, capable of turning the tables on the grim outcomes of this condition, and perhaps also for the aging field in general.

4. Dai L, Qureshi AR, Witasp A, Lindholm B and Peter Stenvinkel P. Early Vascular Ageing and Cellular Senescence in Chronic Kidney Disease. Computational and Structural Biotechnology Journal 2019:17, 721–729.

Creativity of Aged Composers, Soloists and Conductors

Arturo Toscanini: the Longevity of Rigor

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Enzo Viccaro

'Beauty is truth, truth beauty': this famous verse by Keats can be an ideal introduction to Arturo Toscanini (1867-1957), who is still today the unsurpassed prototype of the modern conductor, as well as one of the clearest and most consistent examples of artistic longevity. This longevity has been nourished over the years by the core of his personality, centered on ethical and intellectual rigor.

Toscanini purified the still uncertain role of the conductor - (a role which became a growing necessity as the orchestra and symphonic style became larger and larger and more and more complex from Beethoven onwards) - from narcissisms, inaccuracies and individual arbitrations. He was both a servant and a scientist of the musical text; he inaugurated the era of meticulous analysis of the score, of the search for the smallest details to bring to maximum coherence and unity in the interpretative synthesis: a formidable intellectual work of preparation which then resulted in the undisputed dominance over the orchestra from the podium, made up of an unequivocal gesture, of an astonishing homogeneity of sound of the various orchestral sections and of the absolute balance between them, of crystalline clarity of phrasing and rhythms.

In Toscanini the physical control of the orchestra is therefore the result of lucidity of mind warmed by an unshakable faith in beauty and art, which age has not scratched, indeed perhaps has even strengthened.

It may be that his temperament has drawn its first lifeblood from his origins, from the warm "Garibaldian and Risorgimento spirit" of his Emilian parents from Parma, Claudio Toscanini and Paolina Montani, a couple of tailors who "sing and love music" (1). In 1886, the nineteen-year-old Toscanini opened

Arturo Toscanini

1. Toscanini Foundation *Arturo Toscanini, biography*
https://www.fondazionetoscanini.it/it/arturo-toscanini-biografia/#bio-grafia

his career as an orchestra conductor almost by chance, after the exploit in a tour in South America in Rio during which, hired as cellist and second choir director, he suddenly took the baton in Verdi's Aida (the conductor had left the orchestra!) and conducted the entire opera from memory, creating a triumph. He embarked on his new path with a determination, perfectionism and dedication that made him, while still young, a living legend.

Toscanini with his grandaughter in Life magazine

He is the one who, at the dawn of the twentieth century, made the analytical and, at the same time, unitary interpretation of the musical score I mentioned earlier, the driving force behind the coherence of all aspects of the staging of a melodrama. He required from musicians, set designers, all workers of his beloved Scala di Milano, absolute unity of intents, according to his ever-clear interpretative idea; he eradicated the arbitrary interventions of the singers, who under his unequivocal gesture had to become docile vocal instruments among the other instruments of the orchestra; he prohibited encores that break the continuity of the scene; he educated the public to consider theatre not as a hedonistic entertainment "but as a body endowed with a moral and aesthetic function that penetrates the life of society and the life of a culture " (2). With Toscanini the figure of the modern conductor was outlined and affirmed as the undisputed master of musical performance, who plays the orchestra as a single gigantic instrument, in a great opera as well as in a great symphony.

For Arturo coherence in art and coherence in life were the same thing: that coherence with which, after the triumphal years at the Met in New York (his second homeland: 7 seasons for 446 performances of 31 operas) and throughout Europe, he dared to challenge the fascist dictatorship when in 1931 he refused to play the anthem of the Fascist national party, *Giovinezza* ('Youth') before the start of a concert; that ethical and civil commitment for which he was called to direct the newly formed Palestine Orchestra made up of Jews who fled from Nazi persecutions in Europe.

In 1937 he returned to the United States at the head of the NBC Symphony Orchestra formed especially for him: and Toscanini - a very modern seventy-year-old, an 'arch-Italian' conquered by the spirit of the New World - sensed the enormous potential of the new media and, always under his iron control, made of the Radio Corporation of America and of the newborn television the means for the widest diffusion of his concerts, with a success that made him both a star and a planetary apostle of great music.

Toscanini's work with the NBC Orchestra proceeded until 1954, when on April 4 he conducted his last concert in New York, with a program of music by Wagner, from *Lohengrin*, *Siegfried*, *Die Meistersinger von Nürnberg*, etc.: he was 87 years old. The radio recording (3) and the direct testimonies of the event are impressive: the great old man led the complicated Wagnerian symphonic masses not only with an intact rigor and determination but also with physical vigor, hearing and memory miraculously intact!

Among the many possible examples that can be extracted from the priceless heritage of the American recordings of the last Toscanini, I propose the performance of the Sixth Symphony in E major op. 68 "Pastoral" by L. van Beethoven, which took place at Carnegie Hall on January 14, 1952 (4). The Italian conductor (who had performed this masterpiece for the first time in 1898) faced it for the last time with his most typical approach: he focused on music, on pure music, purifying Beethoven from all the literary, philosophical, psychological suggestions accumulated through an inveterate romantic tradition; the descriptive ideas that accompany the text of the Symphony - "memories of country life" - were treated by Toscanini according to the precise Beethovenian indication, "mehr Ausdruck der Empfindung als Malerei", that is "more expression of feeling than painting". Listening, the result is of an unparalleled clarity: the fine interweaving of instrumental lines of the score is rendered with a millimeter perfection. Just to mention some examples among the thousand possible, the spring attack of the first movement *Allegro ma non troppo* is splendid in its classic sharpness; the second movement *Andante molto mosso* is chaste as "a great *Invention* of Bach" (*G. Pugliese*); the third movement *Allegro* ("Merry Gathering Of Country-Folk") is redeemed from any rustic heaviness thanks to relentless precision; the final *Allegro* and *Allegretto* ("Thunderstorm, Tempest" and "Glad And Grateful Feelings After The Storm") are simply indescribable for the flexibility of the musical phrasing, the plastic beauty of the instrumental timbres, the enthralling rhythmic drive: the acme of an 85-year-old interpreter!.

All this really seems to confirm the theses of the great Jungian psychologist James Hillman on the 'force of character' (5) as a fundamental unifying energy of the personality, and on being true to yourself as the secret of a lasting that transforms the burden of years into wealth: the wealth, in this case existential and artistic at the same time, of an heir, in the middle of '900, of the Italy of Manzoni and Verdi.

2. *Ibidem*

3. *Toscanini conducts Wagner*; CD Music & Arts, 2009

4. L. van Beethoven *9 Symphonies*; NBC Orchestra - Arturo Toscanini; RCA (5 CD)

5. J. Hillman *The Force of Character And the Lasting Life*; Random House USA inc., 2000

FOCUS ON

THE INTERNATIONAL DAY OF OLDER PERSONS

The Event in Italy

Naples, September 30, 2021

An Appeal for the Establishment of Ministries for Seniors in all Countries of the European Union

Natale G. De Santo, Jože Gričar, Jochen Ehrich

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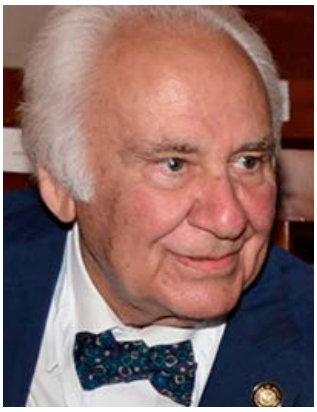

Natale Gaspare De Santo

The European Association of Professors Emeriti (EAPE) previously expressed great interest in establishing Ministries for Seniors in all countries of the European Union (1,2). This request was renewed at a recent conference held on the occasion of the "2021-World Day of Older Persons".

We think that there are many reasons for starting this initiative with a kind of "arrow head" of retired scientists and artists. In fact, the c*reativity of artists and scientists in their late years is remarkable and a cultural strength.* Among these, professors emeriti are a special category of retired persons. They belong to the elite of all cultural enterprises of a nation. They are "analogue and ambulant libraries" because more than 90-95% of actual knowledge that counts in their disciplines has been generated during their academic careers. In addition, they have been able to meet the needs of two generations of university students and young laureates who later became part of the leading intellectual class. Compared to the normal population, their life span is mostly longer because of healthy ageing due to their improved living conditions. Moreover, most emeriti have developed high ethical standards and feel morally obliged to support less privileged groups in society.

The EAPE established, in 2020, a Committee on *Meeting the Needs of Children and Old-Olds*, which is based on Alcmeon of Croton who stated, in the sixth century BC, that "human beings die because they cannot join the beginning to the end".

In 2017, Martha Nussbaum celebrated the fact that retirement in USA was no longer linked to age. She wrote in collaboration with Saul Levmor- a Professor of Public Law- a seminal book on "*Aging Thoughtfully*" in which she expressed the concept that it was the end of a discrimination against old age. This discrimination still persists in Europe where people can retire at 60-70 years of age if they are willing to abstain from paid work. After retirement a pension is, by definition, incompatible with any kind of extra paid work. Does this mean that people are invited to enjoy their pensions and to substitute the

1. Gričar J. All countries need a Minister for Seniors. Bull Eur Assoc Prof. Emer 2020; 1(S1): 158.

2. Gričar J. Minister of Seniors Appointment. Bull Eur Assoc Prof Emer 2021; 2(3): 51-52

fullness of their working days with an eternal "hedonistic emptiness"? Marta Nussbaum, who is now 74, is not a lady achieving leadership because of a rule establishing a quota for women, (in Italy we speak about quota rosa/ pink quota). Rather she is a distinguished Professor of Ethics and Law at the University of Chicago, who has been awarded more than sixty honorary degrees and currently (2022) teaches 3 days a week.

Given the growing proportion of elderly people in the total population of most countries, it is encouraging to see that some countries have established ministries responsible for senior citizens. This was achieved in Australia, Canada, Malta, New Zealand, Scotland and Wales: The ministers have different titles such as Minister of Seniors in Canada, Minister for Aged Care and Senior Australians in Australia, Minister for Seniors in New Zealand, Minister for Older People and Equalities in Scotland and Older People's Commissioner for Wales (1,2). Australia, in the Asian context, is the fifth economy after China, Japan, India and Korea, and the 12th world economy for its volume. In addition, as far as human development is concerned, (it includes instruction, life expectancy and what in Italy we call Prodotto Interno Lordo (Gross Domestic Product) it is second preceding Canada and many northern countries in Europe. Canada enjoys one of the best economies worldwide and has great attentiveness towards seniors, perhaps the country with the greatest attentiveness.

The German poet, essayist and physician Gottfried Benn-nominated for a Nobel Prize five times - wrote in *Altern als Problem für Künstlers* that in the last four hundred years 150-200 geniuses determined the cultural progress of Western Europe (3). Half of them were old-olds. The board members of the EAPE Bulletin fully appreciate the creativity of artists and scientists and had the privilege of publishing an original article on "complexity" coauthored by Edgar Morin, one year before his hundredth birthday (4,5). In addition, we greatly appreciate that Galileo Galilei at 75 years of age published, in 1638, "*Discorsi e Dimostrazioni matematiche intorno a due nuovescienze".* Recently, the late Sir Michael Athiyah-one of the greatest experts in geometry and recipient of the Field Medal and the Abel Prize- and former President of the Royal Society - at 88 years of age, demonstrated the validity of the hypothesis of Walter Feit and John G. Thompson on the theory of groups (about the symmetry in geometry and algebra) (6). Furthermore, Roberta Sinatra and her co-authors have published in *Science* in November 2016, a study on "*Quantifying the evolution of individual scientific impact*" on the career of scientists. They showed that many scientists received the Nobel Prize for the part of their research that had been performed when they were retired and out of the academies. Another typical example was John Fenn who received the nomination for chemistry in 2002, for research done many years after retirement.

In the USA, older scientists obtain the majority of grants from the National Institutes of Health. This has been a reason for a debate in June 2016 in the *New England Journal of Medicine* about the reasons that make the older scientists so successful and its consequences on the USA scientific enterprise and the way to solve the problem (6).

Indeed, many artists including David Bailey, Montaigne, Katsushika Hokusai, Henry Moore, Oscar Niemeyer have produced masterpieces in their late years. Titian at age 99 painted *Danae* that can be seen at Museo di Capodimonte in Naples. We know that while working on this masterpiece he asked his collaborators to bring him all past works still in his possession and his comment was "that until that very day he had been just a weak canvas-knacker, a dauber". Rembrandt painted many self-portraits during 1629-1663 and their quality and power did not decay with aging. In addition, at Rijks Museum in Amsterdam, one can admire his Isaac and Rebecca (*The Jewish Bride)* that has been defined by Roderick Conway "as one of the most exciting studies on aging and on a life lived with fullness" (6).

Leonardo in his late days was nominated by Francis I of France "first painter, architect and engineer of France". During those years he completed *Mona Lisa* and refused to sell it to the king, since he wanted to enjoy it until his own death, being aware of its outstanding value.

Why Ministers of Seniors in the European Union?

After retirement, many old people continue to work or take care of their grandchildren or of other people needing help. Thus, they help others rather than requesting help for themselves. The younger generation can learn from seniors - from primary school to university (1,2) in every field of science, technology, art, music, etc.

3. Benn G. Alters als Problem für Künstlers (Aging as a problem for artists). J.C. Cotta'sche Buchhandlung Nachfolger GMBH, Gegr. 1659, Stuttgart, 1954.

4. De Santo NG, Campanella L, Bonavita V. The Capital of Knowledge Bull Eur Assoc Prof Emer 2021; 2(5): 89-90.

5. Morin E, Gembillo G. Complexity. Bull Eur Assoc Prof Emer 2020 ; 1(2): 20-21.

6. De Santo NG. Créativité et découvertes scientifiques après 65 ans. Bull. Acad. Natle Méd., 2017, 201, nos 7-8-9, 1335-1347, séance du 10 octobre 2017.

Becoming a minister for Seniors means to inform and network with politicians about the needs of the ageing society which is a great economical problem in all countries. All actions for healthcare and social welfare must be scrutinized and filtered through the eyes of the older generation before being implemented. A Minister of Seniors can help other governmental levels to understand the real needs of aging persons. The purpose of all these activities is to grant to the aged a good quality of life. Harmonization of different interests in the governments should primarily involve the Minister of Health, Labour, and Social Welfare plus the whole set of initiatives favouring active aging. First of all, there will be the need to support the development of gerontology and geriatrics. The challenge should not only be related to curative medical care. Aged persons - who do not want to step back - should be offered the possibility to continue their activities in their families, in their profession and in expanding their talents.

In conclusion, politicians will have to make sure that all actions of supporting aged people reach adequate, attainable and attractive goals. All governmental services must be properly coordinated. In addition, aged persons willing to work, and capable of doing it, should be allowed to continue their jobs if their mental and physical status allow. The real problem will be to generate inter-generational programs capable of avoiding confrontations and social isolation. Well-coordinated programs will also help younger persons to achieve a better awareness about aging and aged persons. In the older generation, this concept will cause a good mood, a sense of wellbeing, self-esteem and a better health status. Finally, such projects may confer a significant role to aged persons in their communities which, in return, provides more and better contacts with younger people. Thus, the aged persons in whom talents and creativity are supported by a sufficient health status might have a role to create a positive atmosphere between the "maestro and his students", between "experience and curiosity" and "wisdom and passion".

How an Old Italian Neurologist can Look at Old Age

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Vincenzo Bonavita

I will start with a citation from Ugo Foscolo (1), a celebrated italian poet, who wrote: "Non son chi fui, perì di noi gran parte, quello che avanza è sol languore e pianto/ **I am not who I was; most of us perished: What is left over is only languor and weeping**. Probably this is a poetical translation of a fragment of the *Elegies of the old age* written by Massimiano, who lived around 500 years a.c. But this is not the point. Foscolo wrote "I am not who I was ", referring to a single old man, but then extended his notation to all people in old age. This extension is arbitrary and I will demonstrate that the extension from "io/I" to "noi/we" can be true or not be true.

In 1975 there were, in Italy, 23 full professors of Clinical Nervous and Mental Disease who were requested by the Ministry of the University and Research to decide if their preference for their own academic future was neurology or psychiatry. All 23 (I was the youngest at that time) decided to choose neurology; it was the time of emerging socio-psychiatry.

Whatever the new academic title, there is no doubt that a professor of neurology has a full knowledge of the nervous system, the most pervasive system in our bodies since there is no organ or apparatus without nervous terminations. If we look at the central nervous system, especially the brain, a true marker of evolution in our species, we find the elective site of single functions. This has been the first history of clinical neurology, followed by the history of the functional integration among the areas, and by research on connectivity.

1. Foscolo U. Non Son chi fui. Poesie di Ugo Foscolo. Milano, Destefanis, 1803

There are two questions to be answered: 1. The physiological senescence of elective funcions of the nervous system; 2. the interference of diseases with physiological senescence. The equilibrium of orthostatic posture changes in time owing to the progressive loss of balancing reflexes. The obvious consequences are falls and fractures. But there is also the interference of many diseases of high prevalence in old age: Parkinson's disease and the so called complex parkinsonisms. But there is also an isolated senile postural instability outside Parkinson's disease, and there is also a pharmacogenic parkinsonism which is observed much more often in old people than in young.

In 1817 James Parkinson described a disease in a small number of subjects, but in old age there is a progressive loss of dopaminergic neurons, which becomes clinically evident only when a neuroleptic drug is given.

The neurologist will not give major attention to the decline of sensitive functions, which are associated more with the decline of peripheral receptors than with a decline of central functions.

The senescence of the central nervous system and especially of brain areas causes the major features we observe in old age: the loss of memory starting from short-term memory loss evolving progressively towards the loss of historical knowledge of the same individual .

Here we can find a deep difference among old people and can debate on the extension by Foscolo of "io" to "noi". There are successful old people, old subjects with moderate hypomnesia and old people with dementia.

Dementia is the consequence of primary central nervous system degeneration which has not, in old age, the syndromic sharpness of the first description by Alois Alzheimer in 1906 (2), concerning a 59-year-old woman. The loss of personal history is true old age. Aducanumab, a monoclonal antibody drug can be useful after an early diagnosis, but can also be useless. Personally, i want to be a successful old fellow in my fourth age with no interest in Aducanumab.

Let me now conclude asserting that my life is still a full life, because at 88 years, and 13 years after retirement, I am continuing clinical debate with young co-workers in the Hermitage Capodimonte and in the *Headache School* founded in 1999 by myself, Gennaro Bussone and Giancamillo Manzoni.

Michel De Montaigne (3) wrote in the second book, Cap. VIII *(On the Art of Conversation): "the study of books is a languid and sluggish procedure, while conversation teaches and coaches".*

Conversation with young people is my message to all of you, in a bidirectional relationship, in which wisdom (my capital of age) finds new stimuli for a life truly rich, though different, owing to acquired wisdom.

2. Alzheimer A. Uber einen eigenartigen, schweren Erkrankungsprozeβ der Hirnrinde. 37 Versammlung Sudwesideutscher Irrenarzte,*Tubingen on November 3, 1906*.

3. de Montaigne M. I Saggi. Milano, Bompiani, 2014.

The Vascular Surgeon and the Needs of Older Patients

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The current data provided through bulletins of the World Health Organization (WHO), Istituto Nazionale di Statistica (Istat), United Nations (UN) unequivocally demonstrate an extension of average life expectancy: 85 years for women, 82 years for men in all highly developed countries, technologically advanced due to the improvement of health organization and the possibility of early medical diagnosis in large sectors of the population and also for mass screening for diseases.

The data provided by Istat and the WHO put cardiovascular diseases in first place for morbidity and mortality, far above neoplasms, infectious diseases and trauma. The pathology that is the most responsible -over 90%- for cardiovascular disease is atherosclerosis, multifactorial, progressive, multi-level (in other words involving different segments of the arterial tree), favored by predisposing risk factors: genetic tendency, family history, diabetes, smoking, hypertension, and abnormal metabolism such as hypercholesterolemia and hypertriglyceridemia.

Atherosclerosis is not limited to senescence/ old age because it is becoming more and more frequent in relatively young people between the fourth and seventh decade who may be affected by serious pathologies such as carotid steno-obstructions, responsible for clinical situations of different entities from less-severe transient ischemic attacks-to full blown strokes; coronary steno-obstructions causing angina pectoris **or** myocardial infarction; aneurysms of various vascular sites; peripheral obstructive arterial disease with effects ranging from intermittent claudication to critical ischemia characterized by pain at rest, ulcers and gangrene; diabetic arterial disease sometimes with a poor prognosis.

In the elderly, over the years, it is almost natural to see sclerosis and calcifications of vessel wall, more or less extensive arterial obstructions, due to the stress that the arterial wall undergoes from the incessant impact of blood flow, in particular at the sites of bifurcations and changes in vascular caliber. These phenomena are favored by the previously mentioned risk factors (1).

Umberto Marcello Bracale

Today, great possibilities are offered by diagnostics which are very often not or less invasive but which have great reliability, are painless and repeatable indefinitely over time. These allow early, accurate diagnoses capable of surgical interventions to prevent major complications. Mass screening is very often carried out on large sections of the population which allows timely interventions to significantly reduce morbidity and mortality.

The modern vascular surgeon must be adequately trained with large experience, able to deal with vascular pathologies in the same way and with similar positive results using both traditional open surgery and endovascular surgery that has registered a definitive affirmation due to improvement of techniques and devices.

The most frequent pathologies that the vascular surgeon is called to correct are shown in Table 1.

Vascular Pathologies in the Elderly that Benefit from the Vascular Surgery

Aneurysms of the aorta and other arterial sites are generally treated with endovascular procedures [Endovascular Aneurysm Repair (EVAR), Thoracic-EVAR, Fenestrated-EVAR]. Of fundamental importance in cases of concomitant pathologies such as neoplasms and abdominal aortic aneurysm, the aneurysm repair with a minimally invasive endovascular approach which is, much less dangerous and has a very short post-operative hospital stay (48-72 hours) allows rapid recovery. This is particularly important since an unrelated laparotomy for abdominal malignancies can lead to aneurysm rupture because of

1. Ungvari Z, Tarantini S, Donato AJ, Galvan V, Csiszar A. Mechanisms of Vascular Aging. Circ Res. 2018; 14: 849-867

collagen lysis induced by operation; moreover, a high occurrence of ruptures may be depending on weakening of aneurysmal wall from surgical dissection or corticosteroid/ chemotherapy administration for associated malignancy management. (2, 3).

Occlusive disease of epiaortic vessels, in particular of the carotid bifurcations for the prevention of cerebral stroke.

Traditional open procedures: carotid endarterectomy (CEA). Endovascular procedures: primary or secondary stenting for restenosis (CAS) (4). Currently, if general conditions allow it, vascular surgeons prefer CEA.

Chronic peripheral obstructive arteriopathies (AOCP) for variable clinical situations: moderate ischemia (intermittent claudication) or severe ischemia - CLI (Critical limb ischemia, pain at rest, ulcers or gangrene).

Excellent results are obtained both with traditional open revascularization and with endovascular procedures that are much less invasive and dangerous for the elderly (5). They have made it possible to treat very distal diabetic lesions affecting medium and small caliber vessels that were once precluded or difficult to solve using traditional surgery. With both antegrade and retrograde or combined approaches, limbs otherwise destined for amputation are saved. The choice between open and endovascular surgery depends on the type, extent, multiplicity of lesions, presence of severe calcification and individual preference of the surgeon.

Main fields of application of the vascular surgeon in the maior venous pathology can be summarized as follows:

Placement of vascular filters with a transfemoral or transjugular approach for the prevention of pulmonary embolism. Thrombus aspiration for deep vein thrombi to resolve clinical pictures of severe edema, cyanosis, pain, functional impotence, prevention of pulmonary embolism or rare cases of venous gangrene. Pulmonary thromboaspiration in cases of manifest, clear pulmonary embolism: these are fatal or highly disabling clinical situations.

Table 1. Main fields of Vascular Surgeon's application
• Aortic aneurysms and other vascular districts.
• Steno-obstructive pathology of supraortics trunks (TSA), in particular of the carotid arteries.
• Peripheral artery disease (PAD). Diabetic arteriopathies.
• Disobstructions for acute ischaemia.
• Locoregional thrombolysis for acute ischaemia possibly associated with endovascular procedures.
• Vascular reconstruction after complex trauma.
• Vascular reconstructions after extensive general surgical exeresis.
• Traditional open hybrid interventions combined with endovascular procedures.
• Positioning of caval filters for the prevention of pulmonary embolism (P.E.)
• Thrombus aspiration for Deep Vein Thrombosis (DVT).
• Pulmonary thrombus aspiration for P.E.
• Embolization for angiodysplasias, vascular tumours, haemorrhage from vascular ruptures.
• Venous surgery: varicose veins, relapses, intervention on the deep venous system.
• Treatment of ulcers: arterial, venous, mixed
• Treatment of primary and secondary lymphedema

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Active and Healthy Ageing

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Introduction

Population ageing is a success story of our social and healthcare systems, but there are still deep differences in the quality of life of older people at local, regional, national and international levels [1]. Frailty and disability are not inevitable consequences of the physiological phenomenon of ageing, but they can be countered by adopting healthy lifestyles along the entire life course [2].

WHO launched the Decade of Healthy Ageing [3] as a global collaboration, aligned with the last ten years of the Sustainable Development Goals, that brings together governments, civil society, international agencies, professionals, academia, media and the private sector to improve the quality of life of older people, their families and the communities in which they live. The areas of activity identified by the decade aim to:

- creating living environments suitable for older people, to facilitate independent living;
- fighting stereotypes about older people;
- integrating health services (1)

Commonplace and negative attitudes limit the freedom of older people and tend to block our society's ability to capitalise on the great resources that older people represent.

International Good Practices for healthy and active ageing

As stated by Kalache & Kickbusch 199 (2), good health in old age does not simply mean the absence of disease; but the combination of a person's physical and mental capacities (known as intrinsic capacity) is a better predictor of their health and well-being than the presence or absence of disease. Thus, integrated services focused on improving the intrinsic capacity of older people have better outcomes and are not likely to be more expensive than services focused on a specific disease.

Different types of good practice are available that contribute in different ways to building accessible, inclusive and resilient communities for all age groups.

One example is the PERsonalised ICT Supported Service for Independent Living and Active Ageing - PERSSILAA project, which demonstrated how it was possible to use digital solutions in the community context to detect and prevent frailty in older people. PERSSILAA innovated the way our care services are organised. From fragmented and reactive disease management to preventive and personalised services that are delivered through local community services and telemedicine technology. The technical service infrastructure that supported these services was efficient, reliable, easy to use gamification (the use of game design elements in non-gaming contexts), interoperability and clinical decision support. The Reference Sites Network for Prevention and Care of Frailty and Chronic Conditions in community dwelling persons of EU Countries – SUNFRAIL project (3) also represents an international good practice, as it proposed and validated a questionnaire to identify the early risk of frailty in the elderly in the context of a bio-psychosocial approach. [4] (4, 5).

Enabling factors for active and healthy ageing

The ongoing Covid-19 pandemic has accentuated health inequalities, while at the same time leading to an increase in social needs (justice, freedom, equality, security, etc.),

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2. Kalache A., Kickbusch I. A global strategy for healthy ageing. World Health, 50 (4), 4 - 5. World Health Organization. https://apps.who.int/iris/handle/10665/330616.

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5. Cataldi M., De Luca V., Tramontano G., Del Giudice C., Grimaldi I., Cuccaro P., et al An Approach to Prevent Frailty in Community Dwelling Older Adults: a pilot study performed in Campania region in the framework of the PERSSILAA project. Transl Med UniSa. 2019;19:42-48. Published 2019 Jan 6.

with an inevitable rise in costs for complex health needs. Economic challenges related to the use of resources and the need to align investments have therefore emerged and system approaches need to be implemented. Network collaborations strengthen the link between local, national and international levels to respond more effectively to the challenges we face. The Reference Site Collaborative Network [5] is a network that connects European reference

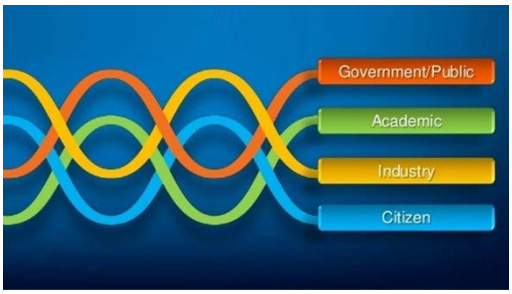

Fig. 1

sites for active and healthy ageing and supports them in exchanging innovative good practices (6), to achieve a "triple win" outcome (Sustainable Growth, Health and Quality of Life & Sustainable and Efficient Health Community Services). The Reference Site architecture is the quadruple helix of innovation ecosystems, including regions, cities, integrated hospitals or care organisations that focus on a comprehensive and innovative approach to active and healthy ageing (Fig. 1).

The Programma Mattone Internazionale Salute (ProMIS) is an example of a national network that promotes regional healthcare in Europe and in the world, as well as Europe and the world in the Health Systems of the Italian Regions in the framework of a synergic collaboration with all the stakeholders involved. ProMIS offers a full involvement of the different actors in the field of health, allowing the dissemination of project methodologies and developing proposals of regional interest and disseminating their results. Finally, during its life, ProMIS has established an in-depth methodology of training and dissemination of project techniques and networking, which is at the basis of European programmes fostering international research initiatives in the field of public health [6]

Conclusions

There is no such thing as a typical older person, which is why public health policies should be aimed at improving the functional capacities of all older people, whether they are robust, care-dependent or intermediate. The physical and social environments in which we live influence active and healthy ageing, and the relationships we have with our environment are shaped by factors such as the family we are born into, our gender, ethnicity and financial resources (Fig. 2). The cumulative impact of advantage and disadvantage in people's lives should be mitigated by reducing the inequalities that underlie much of this diversity.

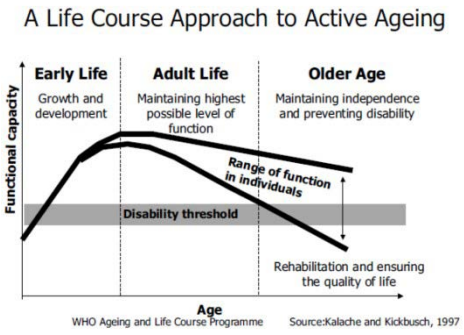

Fig. 2

Our efforts as a society should be directed towards avoiding stereotypical views that lead to discrimination on the basis of age: in fact, only a small proportion of older people are dependent on the care of others; indeed, older people tend to use health services less often than younger adults, although long-term care bridges the gap. Older people make many contributions to their families and society through taxation, consumer spending and other economically valuable activities.

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Lifelong eLearning & eEducation

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The two-hour Zoom meeting of the Professors Emeriti Network on September 29, 2021 was dedicated to the celebration of World Senior Day (1). The theme of eLearning and eEducation affects all generations. It is important also for retired professors who need to update their knowledge by learning the new things they need for peaceful active aging and to discover the opportunities where and how they can help make lifelong learning possible and available to all.

The program included a comprehensive presentation of lifelong learning and education opportunities, prepared by the meeting chair, Associate Professor Lučka Lorber, University of Maribor. The questions raised by the possibility of using modern eTechnologies and their impact was presented by Professor Emeritus John Brennan, Open University, United Kingdom.

Libraries are an important source of learning and education (2). Jürgen Küssow, Vice Director, Head of Network Services, Swiss Library Service Platform presented the echoed experience in successfully connecting all resources in more than 470 libraries in Switzerland. Mateja Pongrac, Librarian, Head of the Learning and Research Support Department, University of Maribor Library, presented their experience in connecting libraries in Slovenia.

Two invited discussants participated. Christine O'Kelly, Age Friendly Global Network Coordinator, Dublin City University showcased the efforts of the world's universities participating in the Age-Friendly University network. Tom O'Mottl, Founder and President, Community Networks for Aging and Place Alliance, Boston, Massachusetts commented on the growing importance of eConnectivity.

These four presentations and two comments had a common emphasis on the importance of "e" in relation to lifelong learning.

Due to the problems caused by the Corona virus, the whole world has realized in a very short time how important it is to accelerate the digitization of all activities of human existence and work. The realization has matured that the pandemic has caused many casualties and great damage, while at the same time triggering many beneficial processes that will remain with people even after the pandemic is over. Knowledge about the opportunities for digitizing learning and the necessary education has spread.

Digital learning (3) is any type of learning accompanied by technology or by instructional practice that makes effective use of technology. It encompasses the application of a wide spectrum of practices, including blended and virtual learning. It includes learning of all kinds at all levels of learning. It concerns people of all ages. It is a component of the overall process of digitization in the world, largely changing what and how people do. In the process of digitization, professors emeriti can do a lot of good for themselves, their families and the community through active participation.

Digitizing is not the same as digital transformation (4). The digital efforts have been proliferating for years as

1. *Lifelong eLearning & eEducation*. Professors Emeriti Network meeting, September 29, 2021. http://eregion.eu/slovenia-professors-emeriti/

2. *How librarians contribute to interdisciplinary research teams*. By Dr. Kelly Miller, Associate Dean for Learning and Research Services and Kineret Ben-Knaan, MA MIS, Research and Assessment Librarian, University of Miami Libraries in Coral Gables, Florida, USA & U-Link – Laboratory for Integrative Knowledge Initiative. Integration and Implementation Insights, September 22, 2020.

3. *Digital learning*. Wikipedia, https://en.wikipedia.org/wiki/Digital_learning

4. *Digitizing Isn't the Same as Digital Transformation.* By Paul Leinwand and Mahadeva Matt Mani. Harvard Business Review, March 26, 2021.

companies strive to catch up with technological innovation. Companies and governments have been digitizing their activities for years, but the epidemic has accelerated their efforts and it is a race to keep up with the technological innovations. These efforts should not be mixed up with business transformation efforts needed for the digital age. Digitization is all about conducting business as usual using the newer tools and digital technologies whereas digital transformation is all about building a long-term competitive advantage to succeed. The future is about not just how we work but what to do to create value. Organizations need to rethink the value they create and transform to create new models for value creation.

The changes triggered by the digitalization of organizations are going deep. They reach out to individuals who work either in the office or from home (5). The realization that working from home is gladly accepted by both employees and employers raises questions about how individuals and organizations should prepare for it. One can thrive and excel when working remotely by adopting the mindset, habits and tech tools of professionals who are even more productive outside the office. Individuals better-start thinking like a "business of one", and that entrepreneurial mindset will transform one's experience of remote work. Working remotely, whether full-time or in combination with time at the office, is the direction for many.

The realization of the necessity of lifelong learning forces us to think about new organizational forms of work of organizations and individuals. We will all need to adapt rapidly to take advantage of the good sides of change and to minimize the negative consequences we will feel.

Leaders will have to decide how much change they can manage, how fast their business can be disrupted and how best to manage the transformation. Without a fundamental transformation, digitization by itself is of no use. Leaders must disrupt themselves to become leaders in the digital age. On one hand, professors emeriti are impacted by the transformation processes. On the other hand, they can help the processes to be smooth, user-centric and encompassing multidisciplinarity. In a changed situation some professions are dying out and new ones are coming (6). This opens up new tasks for designing future educational programs where professors emeriti can help with advice.

5. *Remote, Inc.. How to thrive at work ... wherever you are.* By Dr. Robert C. Pozen and Dr. Alexandra Samuel. Harper Business, New York, 27 April 2021, pp 290.

6. *Online Education as a Discipline.* By Steve McCarty, Adjunct Professor, Osaka Jogakuin University & President, World Association for Online Education. Academia Letters, March 2021.

Opportunities of Lifelong eLearning and eEducation

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Introduction

People, regardless of age and *digital literacy*, can't be ignored when designing and introducing new digital initiatives and tools. Senior persons are often neither reached nor targeted by digital education initiatives. "Everyone is entitled to realization of the economic, social and cultural rights indispensable for his dignity and the free development of his personality" (art. 22 of the Universal Declaration of Human Rights). If we want human rights to be respected, the coming digital world must be designed with and for all citizens.

In the context of the pandemic, that showed digital inclusion is more important than ever to fight loneliness and isolation and to fully participate in society. The measures to constrain the spread of the virus have indeed intensified the use of digital technologies in all areas: work, care, banking and shopping, social interaction, teaching and learning, etc.

Today a considerable number of people don't know how to use those tools and have no alternative, as previous processes are not available anymore. A way for older people to play an active role in society is *lifelong learning.* Investing in people's knowledge, skills and competences throughout their lives forms part of the response to the challenges of ageing. It is true that no one has spent enough time to ensure that the general level of digital literacy of all age groups is high enough to allow citizens to get familiar with and to use those new tools. A lot of intergenerational learning happens informally in the community: in activities around libraries and museums, cultural, sports or other associations, religious institutions, etc. Varying needs and capacities of older people should be taken into account in the organisation of urban infrastructure and services. Many cities already take into account health, gender equality and other considerations in their urban mobility plans. *Accessibility* contributes to social inclusion. Adult learning brings considerable benefits for learners themselves and for the wider community. Furthermore, adult learning contributes to all policy areas (e.g. economy, innovation, environment, democratic values) covered by the European Commission (1) as all depend to some degree on the skills of people.

Investing in people's knowledge, skills and competences throughout their lives forms part of the response to the challenges of ageing. It is also a way for older people to play an active role in society. Lifelong learning is most effective when it starts early in life. *Intergenerational learning*, including mentoring or experience sharing, allows the young and old to exchange knowledge and competencies. *Volunteering* activities can promote intergenerational solidarity and cooperation, creating value and benefiting young and old alike in terms of knowledge, experience and self-esteem.

Future adult learning policies

Governance must respect the principle of balanced involvement of all target groups in lifelong learning, with special emphasis on older adults regardless of their status. It is necessary to respond to future needs in the field of skills development, digitalization and sustainability. It needs to be supported, organizationally, in terms of staff and financially. An important partnership with higher education institutions is necessary and which is currently not involved. In this context, it is necessary to provide equal access to higher education, because it is crucial to acquire knowledge. A holistic approach is needed, based on networking and partnership between stakeholders in formal, non-formal and informal experimental education and learning, the public and civil sectors.

Educationally-disadvantaged are not only individual groups of the population, but also residents of individual regions and smaller places where they have difficult access to educational opportunities. It is necessary to ensure a minimum-quality standard of adult learning, develop and provide national systems or models of internal and external quality assessment from the aspects of programs, processes, implementing organizations and educators.

Presentations of good practice from different European countries are always useful. The problem is that only the involvement is measured, not the outcomes and effects, the satisfaction of the participants. Older people need digital skills-mechanisms are needed to support this on all sides. Adult learning need financing sustainability for good life; adult learning is a right for all (2). Higher Education Institutions should make their systems more inclusive which is an essential aim of the European Higher Education Area (EHEA), because our populations become more and more diversified not only because of immigration but also because of demographic changes (3). Universities must take the responsibility, break their walls and open themselves to society. Their vision should focus in the future on: Teaching and Learning (combined with eEducation and eLearning), Research and Innovation, Culture (Quality Culture) and overcoming age-related stereotypes (4).

The Center for Professors Emeriti and Retired Higher Education Teachers at the University of Maribor conducted an online survey in July 2020. The group members were asked to give five answers to the question 'What are the most important opportunities for eLearning and eEducation?' We received 29 responses from 10 countries. Participants presented different views (5) and highlighted several aspects of concrete examples of the impact of eLearning and eEducation on social relations between teachers and students and to the environment. Interestingly, despite the geographical diversity of participants, there are no differences in perceptions of utility and basic approaches to eLearning and eEducation (6). The majority opinion is that distance learning can successfully replace teaching at institutions in situations such as the Covid-19 pandemic and that it is affordable and, in most cases, independent of location.

1. https://op.europa.eu/en/publication-detail/-/publication/d918b520-63a9-11eb-aeb5-01aa75ed71a1/language-en

2. https://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=8260&furtherPubs=yes

3. https://ehea2020rome.it/

4. https://eua.eu/resources/publications/983:pathways-to-the-future.html

5. http://eregion.eu/attached-documents/12141

6. http://eregion.eu/attached-documents/12142

Future challenges

The importance of the transfer of knowledge and skills from the older to the younger generation and vice versa - the intergenerational approach - should be emphasized. For these purposes, it may be necessary to adapt legislation e.g., simultaneous presence of older and younger people at the workplace with the aim of passion and knowledge and experience.

Strengthen the knowledge that personal growth is strengthened by linking formal, non-formal and informal education and learning.

Strengthen the importance of education for the acquisition of general competencies taking into account the green transformation of society, which shows the need to develop competencies in this area.

Make better use of the opportunities offered by modern technology to acquire new knowledge, while also providing some security in accessing and working remotely. It is necessary to protect yourself from false information.

Provide material conditions for education (ICT equipment) for older adults and providers.

eServices for Seniors 55+ Guide in Slovenia

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The purpose of the eServices for Seniors 55+ Guide) is to facilitate the acquisition of the necessary data from credible sources for seniors and their caregivers. Therefore, data about eServices must be available at the time someone needs it. The search must be simple so that the user can use it to obtain information on how to solve the problem she/he is having. Data published in the Guide is available on the website of the organization that collects, maintains and provides access to it. For each organization, data is also published about the contact person in the organization who can provide additional data by email or telephone.

The idea of having a Guide, online, in Slovenia was thought of at the monthly meetings of the emerging eSeniors network in Slovenia during September 2017 - March 2018. The meetings were a meaningful continuation of the open meetings and consultations in 2016 and 2017 (1, 2).

The network members have started to collect data on similar efforts in other countries in which the Guide is published. It turned out that they have the most experience in Canada, where they have been publishing such a Guide on the Internet and printing brochures for many years. They do this at three levels: at the level of the state of Canada (online version only), at the level of the provinces and at the level of major cities (3). Those interested can choose the available language in which the brochure should be printed.

The decision to issue the Guide in Slovenia was made after the *eServices Provision for the Elderly 55+ Consultation* on 12 September 2018 (4). The first edition of the Seniors Services Guide 55+ in Slovenia was published as a prototype on the website and printed in Slovene and English on 9 April 2019 (5). The 2021 edition was presented at the meeting *Collaboration of the Municipalities in publishing the eService Guide for Seniors 55+ who take care of their parents, who are 75+* in Slovenj Gradec, Slovenia on 1.10.2021 (6). The

1. Silver eConomy Development Meeting in Ljubljana. eRegion.eu, 8.6.2016, http://eregion.eu/8-6-2016-silver-economy-development-meeting-ljubljana/

2. Slovenia eSeniors: eInclusion in Active Aging Consultation, eRegion.eu, 29.9.2017, http://eregion.eu/29-9-2017-slovenia-eseniors-einclusion-active-aging-consultation/

3. Programs and services for seniors. Government of Canada, https://www.canada.ca/en/employment-social-development/campaigns/seniors.html/

4. eServices Provision for the Elderly 55+ Consultation. eRegion.eu, 2.9.2018, http://eregion.eu/12-9-2018-eservices-provision-elderly-55-consultation-ljubljana/

5. Seniors Services Guide 55+ in Slovenia. eRegion.eu, http://eregion.eu/seniors-eservices-guide-55-slovenia/

6. Collaboration of municipalities in publishing the eService Guide for Seniors 55+ who take care of their parents, who are 75+. Slovenj Gradec, Slovenia. eRegion, Slovenia 1.10.2021, http://eregion.eu/seniors-55-eservices-guide-edition-2020/

meeting in Slovene language with 40 participants was organized in honour of the World Day of Older Persons.

The Guide publishes data on services provided to seniors by organizations in the municipality (one page for each organization): health community center, hospital, home for the elderly, pharmacy, municipal administration, local unit of the Institute of Public Health, adult education center, center for social work, secondary medical school, faculty of health and social sciences, library, museum, cultural center, gallery, utility company, Red Cross committee, pensioners' association, disabled people's association. These organizations acknowledge that they are not good enough at providing data to seniors over the Internet. The Guide shows them that they need to sharpen their websites for seniors. This is an important value of the Guide: seniors centricity.

In Slovenia, the simultaneous publication of the Guides in the municipalities Slovenj Gradec & Trebnje confirms that it is possible to create a Guide in a uniform manner; its content is in accordance with the circumstances in each municipality. There are 212 municipalities in the country, which has a population of 2,207,000. The number of required Guides is 63, as many as there are health community centers operating in 479 locations. With the Guide, a model is created on how to present data on services for seniors.

For further research, the question of possible transferability of the described model to other environments arises. We assume that Guide development in neighboring countries cannot be much different from the experience in Slovenia. It would be useful to test this in collaboration with groups from a few countries. Professors emeriti can help in such an experiment from two perspectives: as seniors - users of the Guide, and as experts in interdisciplinary and intergenerational cooperation.

In preparing the Guide 2021, we came to the following conclusions:

The starting point for making a Guide is the realization that we have a problem: a Guide is not available. The condition for its delivery is the willingness of the stakeholders to cooperate.

Data on services for seniors 55+ is available in the organizations that offer the services. However, each organization presents data in its own way. It often takes effort to find the data someone needs. This causes problems for seniors.

A Guide is a simple online or printed brochure. The road to it, however, is quite long, because it is a new thing in which representatives of numerous organizations are participating. Experience in Slovenia showed that the process from the creation of the first ideas to the usable version of the Guide took three years; one year was lost because of Corona.

The environment for which the Guide is made is the local community - the municipality. It is an environment in which people live and seek help in their vicinity when they need it. Its upgrade is an annex to the municipality Guide on services provided by the related organizations at the state level. For example, health insurance, pension insurance, Ministry of Health, Ministry of Labour and Social Affairs, Ministry of Public Administration, Employment Service, Banks Association, bus & railway services.

The most important organization for the construction of a Guide is the health community center. There, they have all health-related data about all the residents of the municipality from birth to death. The second most important organization is the municipal administration, which has the best overview of the services for seniors provided by organizations in the municipality. At the municipal level, funding is often provided for the provision of the range of services that seniors need. The support of the mayor is essential.

It is recommended that the structure of the Guide is the same for all municipalities. The content depends on local circumstances in the municipality, however. The same look facilitates comparability which is important for fostering innovation and good practice dissemination.

Editing a Guide is a demanding process, for which it is possible to recommend the involvement of the editor of a local newspaper (newsletter), because they have the necessary experience in editing websites and printed materials.

To start publishing a Guide, an online version has to be prepared. When that is completed, everything is ready for *printing* the Guide-which is a must. To have transparency of the data, even those who are otherwise skilled in using the Internet like the printed brochure.

Delivering a printed copy of the Guide to every home in the municipality is a necessary but demanding process. It makes sense to distribute the Guide as a supplement to a local newspaper once a year.

It is recommended to accelerate the production of the Guide in all municipalities of the country and to encourage the cooperation of municipalities in order to exchange experiences.

The online connectivity of *Municipal Guides* enables the upgrading of data at the state level. The online *State Guide* can provide a comprehensive overview of the data and allow for data cross-linking according to the user's interest and analyses requirements.

A Guide is a "living thing" since it needs to be updated once a year. It is expected to be more comprehensive and transparent each year.

From a methodological point of view, it is possible to propose the development of a Guide as a prototype and to direct the participation of all persons according to the principles of open innovation.

Dysfunctional Vs Adaptive Ageing

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Ageing is not an illness. It is a normal, evolutionary process within the normal life cycle. Yet, there is a paradox here. Although it is an evolution (a process commonly understood to be a step forward) it is in fact a step backward as it is linked to dysfunction.

A question arises at this point.

Would it be acceptable to consider that, along with its obvious negative aspects, ageing also has positive sides?

The fact that memory, the capacity for learning, cognitive functions, response to stimuli, acuteness of the sensory organs, sexual function etc. become weaker, is, of course, on the negative side. Yet, one wonders whether these negative changes also have positive sides. The lowering of the affective tone may contribute to indifference, societal disengagement and attention to self but it may also contribute to a calm and objective approach to problems and life in general. Introversion may prevent social interaction but it may also contribute to the strengthening of imagination, constructive dialogue with one's self and reinforcement of intuition. Weakening of recent memory is certainly responsible for limitations in intellectual work but it also helps in the recall of beautiful or beautified memories of the past (as past memory remains intact for longer). Weakening of the learning capacity is, of course, responsible for perpetuation of acquired habits and for stereotypical thinking (always 'within the box') but it also contributes to consistency, reliability and the preservation of tradition ('the wisdom of the past').

In view of the above, which are the parameters that will determine whether ageing will eventually be dysfunctional or adaptive, a cause of suffering or a blessing, whether it will be the fulfillment of life's expectations or a passive anticipation of death?

Personality is the basic parameter that will determine this response. The character structure of each one of us before old age will determine the way in which we will respond to ageing. Because we do respond to ageing; we do not accept it passively. We mobilize our remaining abilities to substitute for the cognitive functions that have left us, we try to adapt to new situations that are either new or we perceive them as new. We try to defend ourselves. Whether this response, which aims at self-defence and self-protection, will result in a benevolent, warm and pleasant person or in a stubborn, egocentric and hostile old man or woman, will largely depend on the way that similar situations have been managed in the past. It will, therefore, depend on the personality.

At this point, one may ask: "Which personality"? Is it not true that personality changes with incoming senescence? Is it not true that personality is dynamic, not static and that it changes with time? Is it not true that epigenetic influences, coupled with brain plasticity, change our personality? Yes, but the degree and the pace with which personality changes depends largely on its structure before senescence. People with a well-structured, mature and adaptive personality usually experience and exhibit a smooth transition to old age. On the contrary, those with personality problems that existed long before old age have serious problems of adaptation which are intensified during old age.

What kind of personality changes occur at senescence? The most important change is the intensification of its basic characteristics. A consistent person becomes obsessional, a talkative person becomes voluble, a person careful with the finances becomes a niggard, a persistent person becomes stubborn, an introverted person becomes a loner. Hence the dictum "When we get old we become caricatures of ourselves".

As a rule, older people become dogmatic, stubborn and excessively conservative. Their way of living is anachronistically consistent with their past lifestyle and, as they rarely renew their clothes, they equally rarely renew their interests, their habits and their relationships with the outside world. Usually, their interpersonal relationships are reduced to basically one person, their companion in life with whom they develop a reciprocal dependence situation.

However, it must be stressed that older people may fall somewhat short in producing new ideas and they lack the vitality and speed of younger persons but they are superior in knowledge, experience and prudence (an Aristotelian ideal).

It must be pointed out that, with reference to occupational rehabilitation of older persons it is important to avoid generalizations. It is true that in most cases some kind of occupation, even part-time, can help in fighting solitude, in restoration of self-respect and in social integration but there are some old people - "the pensioners of the rocking chair"-who are happy with providing advice to their children and playing with their grandchildren. Nobody can tell whether this kind of productivity is superior or inferior to the productivity envisaged by social workers and other proponents of occupational rehabilitation.

It is generally believed by those who are prevention-oriented that we need to prepare ourselves for old age when we are very young. What does this preparation encompass?

1. Avoid becoming a caricature of yourself. Marked personality characteristics (especially unwanted ones) have to become milder. Difficult to achieve? Yes, it is difficult.

2. Become more flexible in order to achieve greater adaptability when confronted with ever-changing circumstances.

3. Fulfill one's psychological needs and expectations on time and avoid delaying their satisfaction for "tomorrow". This "tomorrow" may never come. Passage from one age to another encompasses the cumulation of small or bigger "delays" in the satisfaction of psychological needs, frustrations and unfulfilled dreams. Now, old age is characterized by review and re-evaluation of the past. This review inevitably brings to the surface all unfulfilled needs of the past.

Realization that, owing to the bio-psycho-social decline related to senescence, these needs will never be satisfied, represents a heavy blow for the old person.

Fear of old age may lead some older persons to denial of senility and consequently to inability to disengage themselves from goals existing at a younger age. However, many risks threaten an older person when goals like beauty, athletic achievements and sexual performance persist and refuse to give place to more realistic goals.

Frustration, ridicule and sometimes depression may follow.

In conclusion, old age has the serious disadvantage of being close to the end of life. Yet, it is only from the heights of this age that one can have a full consideration of life. Whether this consideration will lead to satisfaction or disappointment will depend on whether life has been lived according to its merits (1,2,3,4).

Acknowledgements

Presented in Athens at the Meeting of the International Day of Older Persons organized by the Association of Professors Emeriti of the University of Athens.

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Senior – More Than a Protocol of Life

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Anton Fabian

The protocol of life arises from the sum total of events, as they have happened over the years. But human existence, life, even the stage of aging, is more than just a protocol, a record of change. Viktor Emil Frankl, a Viennese neurologist and psychiatrist (1905-1997), also discusses "more" about spirituality, thinking interestingly about the value of time and transience in correlation with the meaning of life. In senior age, they like saying: the good old times, which means lamenting the past. But according to Frankl, the past is the only true fact. What passes from the present to the past is dialectically both abolished and preserved (1).

Frankl used an hourglass image as an example. The sand flows from the top to the bottom and stays there. The present became the past. If something has happened (an opportunity to create, experience, or suffer), it has become a reality, it is forever (for all eternity) preserved. According to Frankl, the past exists independently of our consciousness, just as a thing exists even when we do not think about it. Even if everyone dies, the past will remain preserved and will exist forever. Everything is evanescent and eternal at the same time. Everything perpetuates itself as soon as it is introduced in the time of our lives (2). So, we do not have to worry about anything not being immortalised, but we are responsible for what is immortalised by introducing it in time.

Man is free and can view the past fatally or learn from it. The immutability of the past stirs up human freedom and should be a challenge to act responsibly. Everything we have experienced, done or suffered, is captured in the protocol of the world, according to Frankl. This protocol cannot be lost. Frankl V. E. (3) writes: Man usually sees just the stubble of transience, but what he/she overlooks are barns full of the past. By the fact that something happened in the past, does not yet mean it is irretrievably lost, all the more so, everything is preserved. Nothing that once happened can be removed from the world. Thus, what matters is the presence formed by our actions.

Frankl also applies his view of time to issues related to human death (4). At the moment of death, man has got nothing available left: neither body nor soul. What occurs is a total loss of the psychophysical *Self*. What remains is just oneself, the spirit-him/herself. One seems to become a film of one's life. He/she is now his/her life lived. He/she became his/her history, both the one that happened to him/her and the one he/she has created. And therefore he/she is also one's hell or one's heaven.

The paradox is that man's past is actually his future. At the moment of death, man does not have (own) his life, but man is life (I do not have life, but I am life). These views correspond closely with the attitudes of Jesus of Nazareth, who said, "*I am the resurrection and the life. The one who believes in me will live, even though they die*" (John 11:25). One must die for this world, but not for the dimension of eternity. This belief belongs to the meaningful whole of life. The senior age deepens this knowledge, cleanses man from superficiality and deepens his spirituality.

In this context, it is worth recalling the content of the message of Pope Francis on the World Day of Grandparents and Seniors in July 2021. It is short, just three pages, and is based on the Biblical sentence at the end of Matthew's gospel: "*I am with you always, to the very end of the age*" (Matthew 28:20). In a time of loneliness and isolation that seniors cannot avoid, it is important to maintain confidence in God's affection: He is with me, to the very end of the age. Pope Francis said "*Sometimes this love of God has got the face of your grandchildren, at other times one of your relatives, old friends or those you met at a difficult time in your life. Embraces and visits are important for each of us*" (5).

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2. Frankl V.E. And Yet Say Yes to Life. Kostelní Vydří, Carmelite, 1996.
3. Frankl V.E. Medical Care of the Soul. Brno, Cesta, 1996.
4. Frankl V.E. Will to Meaning. Brno, Cesta, 1997.
5. Pope Francis. Message on the First World Day of Grandparents and Seniors, 2021.

At other times, God's love has a wise, timeless face when we pray, read the Psalms, read the Bible. The Pope writes: "*Let us not be afraid to remain moved by the Lord's faithfulness. Scripture will help us understand what the Lord is asking of us in our present lives ... I myself can testify that I accepted the vocation to become the Bishop of Rome when I had reached retirement, so to speak, and I thought I would not have to be doing anything completely new. The Lord is always with us, always with new challenges, with new words, with His consolation, and He is always with us. You know that He is eternal and that He never retires*" (5).

If "*I am with you all*" holds true, then the doubts and questions that open up our rationalism must not decompose us. For each one of us asks, what will happen to me? How do I manage my retirement period? My strength is slowly running out and I don't believe I could do more. How can I start behaving differently when a habit has become the rule of my life? How can I care about somebody who is even poorer when I care so much about my family? How can I broaden my view if I can't even leave the house where I live? Isn't my loneliness too heavy a burden?

If "*I am with you all*," holds true, then each of us has their importance, value, and significance. In the Encyclical letter (6), the Pope wrote: "*We must all take active part in the rehabilitation and support of a wounded society*." Everyone is needed to build a world. We are all debtors to each other. No one will save himself on his. We are all brothers and sisters. That is why you are needed, too. Seniors are also called upon to "come out of him/herself".

In the next part of the message, the Pope writes about three pillars that can support the new construction of the world: 1) desires - dreams, 2) memories, 3) prayer. The true mission of every senior is to remember and pass on memories to others. Nothing can be built without memories; without foundations man can never build a house. And memory is the basis of life. And old people's prayer can help more effectively than the restless activity of many others.

The whole message is full of encouragement, because it assures the affection of God (*I am with you*), which can be read from the face and embrace of loved ones as well as from the wisdom of Biblical words. It inspires us to revive our dreams, memories, and prayers, which form the supporting system of our personal spirituality. And it is spirituality that sheds light on the seniors' realistic and hopeful thinking about life.

This article was given as a lecture at the World Day of the Older Persons at the UPJŠ Faculty of Medicine in Košice on 11 October 2021.

6. Pope Francis. The Encyclical Letter "All Brothers" on fraternity and social friendship. Article 77, October 3, 2020.

THE INTERNATIONAL DAY OF OLDER PERSONS
The Event in Slovak Republic

Are the "Oldest Old" Exceptions or Not?

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In developed countries of the world the portion of the population over age 65 is growing with an accelerating pace, faster than the whole population. Moreover, within this group there is a shift towards very old age – over 85 years. Between 1950 and 2020 the world population tripled from 2.9 x 10^9 to 7.8 x 10^9 and life expectancy rose in the same period from 47 to 73 years. There is a redistribution of demographic structure in most developed countries and an unhealthy shape of the age pyramid (1). The corresponding increase in the need for medical services, as well as long-term care, was already recognized 50 years ago and gave rise to two medical disciplines. Gerontology is a scientific discipline searching the biochemical and biological background of the aging process and geriatrics deals with the practical medical problems of the old people.

In medical statistics *mortality* is the number of deaths in the course of one year for 1000 people. The *cumulative mortality* from birth to death of a cohort follows an S-like path, and is termed as the *Gompertz curve.* From this curve an important variable, the *median life span* can

1. Garmany A, Yamada S, Terzic A. Longevity leap: mind the healthspan gap. Regen Med 2021, 6:57, doi 10.1038/s41536-021-00169-5.

be estimated. This is the age at which 50 % of a given population have already died (and the second half is still living). The median life span is equal to the *life expectancy at birth* and is a variable which is continously increasing. From the XIXth century its value has approximately doubled in most economically developed countries. The improvement in the past was associated with better quality of water, food, housing, general acess to medical care, vaccination, and later the discovery of antibiotics. These measures first decreased the mortality of newborns and young (2). From the second half of the XXth century a reduced mortality ensued also in older people. On the other side the *maximum life span potential (MLSP).* which represents the longest-living individuals in this population is a biological constant. For humans its value is around 120 years. The explanation of the different features of medium (variable) and maximum (constant) life span is simple: in the past the number of centenarians was very low, and now is many times higher. An example: in Germany the number of centenarians in 1938 was 4, in 1975 it increased to 1400 and now is more than 4000.

The main characteristics of aging from medical point of view are as follows: (3)

- Increased mortality with age after maturation.
- Increased number of somatic mutations, shortening of the telomeres and general destabilisation of genome.
- Cellular senescence associated with changes in cellular metabolism, as well as autocrine, and paracrine secretion patterns.
- A broad spectrum of progressive deterioration of both somatic and mental functions.
- Decreased ability to respond adaptively to environmental changes.
- Increased vulnerability to many diseases and general frailty of the body.

On first sight the rise of median life span can be celebrated as a victory for civilisation, but on the other hand it is not associated with an equivalent rise of years in health in older age-termed as *disease-free lifespan or healthspan*. Many old people spend more and more years with chronic diseases. The gap between lifespan and healthspan is currently around 9 years. 15 – 20% of last years of human life is spent in *late-life morbidity* increasing the need for medical and social care, and considerably decreasing the quality of life. It was expressed in a comment to a series of papers published at the turn of the millenium, in *Time Magazine*, about the possibilities of prolonging of life up to 300 years. The mother of the Chief Editor responded simply: *don't do it!*

Despite this scepticism some futurologists do not give up the idea that it is possible for the maximun life span to be prolonged with pharmacological and genetic interventions. The answers to this proposal can be formulated both from old mythological and literary examples (Table 1) but also from serious scientific considerations (4). The authors analysing global demographics stated that improvements in survival with age decline after age 100. The age of death of the oldest persons has not increased in the past 30 years despite a significant increase of median life span. The maximum documented age at death is that of Jeanne Calment, a french woman who died in 1997 aged 122 years.

The first report on healthy aging is that of Galenos (*De Sanitate Tuenda*, 175 AD, English translation by I. Johnston, 2018 (5) who described aging as a physiological process and cites two cases: Antiochius, a doctor practising in his eighties and Telephus, a philosopher living nearly 100 years. Galen himself had a long life and died in age 87 in Pergamon.

The names of other famous persons living long, creative lives are summarised in Table 2 and the *"blue zones",* regions with the highest number of healthy centenarians (6) in table 3. A very important feature of most very old persons is a short, often disease-free period before death.

In the next paper we will try to find answers to the most important question, that is, how to compress this morbidity period to minimum in individuals and smaller and bigger groups of society.

Table 1. Two examples of pitfalls associated with prolonged life as seen in mythology and literature

• *Greek mythology:* Tithonus, a human lover of the goddess Eos, after a quarrel between Eos and Zeus, acquired immortality but not eternal youthfulness.
• *Jonathan Swift, Gulliver's Travels, 1726, Part III:* A Voyage to Laputa, Balnibarbi, Luggnagg, Glubbdubdrib and Japan. On the island of Luggnagg, he encounters the struldbrugs, people who are immortal. They do not have the gift of eternal youth, but suffer the infirmities of old age and are considered legally dead at the age of eighty.

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Table 2: Famous people living a long, active life and some of their work and activity in late age	
Tiziano Vecelli, artist • Pieta, age 98	1477 – 1576
Verdi Giuseppe, compositor • Falstaff, age 80	1813 – 1902
Churchill Winston, statesman • Prime minister of UK during WWII and in 1951 - 1955	1874 – 1965
Casals Pablo, cellist, composer, conductor • Conducted his last concert with the youth orchestra at the Jerusalem Khan Theater, 1973	1876 – 1973
Picasso Pablo, artist • Le couple, age 86	1881 – 1973
Merle Robert, novelist • 13 volume series "Fortune de France" finished at age 94	1908 – 2004
Kňazovický Ján, surgeon • Founder of Kosice Medical Faculty	1893 – 1987
Queen Mother • Mother of Queen Elizabeth II	1900 – 2002
Moiseyev Igor, choreographer • Leader of Moiseyev Ballet up to advanced age	1906 – 2007
Winton Nicholas • Saved the life of 669 jewish children in Prague during the Holocaust	1909 – 2015
Douglas Kirk, actor, director	1916 - 2020
Glenn John, astronaut • First flight in 1962, second in 1999 (age 77)	1922 - 2016
Elizabeth II, Queen of United Kingdom • On throne from 1953 (68 years)	1926 – present

Table 3: The blue zones of the world
Okinawa, Japan
Ikaria, Greece
Nicoya, Costa Rica
Loma Linda. California, USA

Acknowledgements

This article was given as a lecture at the World Day of the Older Persons at the UPJŠ Faculty of Medicine in Košice on 11 October 2021.

The New York Times: "Ikaria, Greece, The Island where People Forget to Die"

THE INTERNATIONAL DAY OF OLDER PERSONS
The Event in Slovak Republic

2021 World Day of Older Persons in Košice

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Katarína Derzsiová

In the introductory presentation Derzsiová Katarína, initiator and coordinator of the event, pointed out the meaning and purpose of World Day of Older Persons (WDOP), celebrated around the world every year in the past 30 years. She pointed out the importance of this day, when the current generation can be introduced to the problems and needs of older people. This day represents an occasion that draws attention to the rapidly growing population of older persons, which is becoming a serious challenge for the 21st century.

The aims of the WDOP: (i) to end inequality, to enable all people to participate in a society with full rights, regardless of age; (ii) To enable professors emeriti, active university professors and other important scientists in retirement to pass on their experience to the younger generation and to further cooperate with them; they should only switch roles from a leader to a member of a scientific team, with full

participation in research and mentoring; (iii) to give seniors the opportunity for a new stage in their academic career; they are ambulant libraries in their fields, they are jewels of wisdom and experience.

The Covid-19 pandemic has changed our lifestyle. At present digital technologies have become our most important means of communication, and it is therefore necessary to ensure that no age group loses the opportunity to communicate due to technological disadvantages.

The question arises, "What can we, as a society, as active seniors, do well for all seniors? Some nations have already understood their role towards the older persons and have set up a Ministry for Seniors (1,2). The Minister for Seniors is solely responsible for older persons and ensures that policies concerning healthcare and financial security are assessed through the eyes of seniors. The Minister is expected to help the government better understand the real needs of seniors. An important area of concern for the Minister should be to ensure that if seniors want to stay in the labour market, barriers should be removed. His primary role is to support the development of gerontology and geriatrics. Pope Francis, during his visit in Košice, reminded young people not to forget their roots, which still need to be watered, their parents and grandparents. Our grandfathers and grandmothers have experiences that can help us endure change, cope with difficult situations, and appreciate the value of life or freedom. Even if their strength gradually decreases and their hearing is lost, the acquired wisdom will not disappear. We thank them for our history and preservation of traditions. We often realize their true value to society as they leave this world (3).

Prof. Uher and Mgr. Kuchelova presented an integrated overview of healthy lifestyle including different modalities of physical activity, judicious diet, and strong social contacts as a prevention of most chronic diseases affecting the old people.

Assoc. Prof. Schroner Zbynek (member of the Slovak Diabetes Association Steering Commetee and head of the Gerontology Clinic of Medical Faculty of Safarik University, Kosice) described the current possibilities of diabetes treatment in older patients with Type 2 diabetes mellitus. Currently there are a high number of newly introduced drugs which can ensure better glycaemic compensation and better quality of life than the classic ones. He demonstrated the possibilities and the caveats of the use of these new drugs according to current guidelines and evidence-based medicine.

Prof. Jarčuška Pavol (Head of Clinic of Infectology and Travel Diseases of the Medical Faculty, Safarik University and a member of the Covid-19 Pandemic Commission of the Slovak Republic) gave a very interesting overview of all aspects of the current situation of Covid-19 in this country and the world. The lecture contained data about the strategy of vaccination not only against SARS-COV-2, but also its combination with vaccination against flu. The analysis of the variable clinical picture of disease was extremely important for general practitioners present at the workshop.

Mgr. Iveta Rajničová Nagyová, Head of the Department of Social and Behavioural Medicine pointed to the problem of the need for integration of health and social care. Without it, it is not possible to achieve improvements in the fight against chronic diseases especially common in the elderly. The Scirocco project is a participatory tool which helps to adopt and transfer integrated care good practices and to facilitate multi-stakeholder dialogues focused on progress towards the implementation of integrated care.

Platová Jarmila, MD, a general practioner and a member of the Steering Committee of the Kosice Medical Association provided an overview of the problems associated with non-integrated healthcare as compared with the past when personalized medicine was provided by general practitioners and pediatricians without the currently-available technological advances.. She stressed the need for co-operation of all interested components of care – general practitioners, outpatient and hospital specialists, paramedical healthcare and social care facilities and institutions.

An unusual point of the WDOP workshop was the lecture of Friedman Nimrod, a student of Kosice Medical Faculty, from Israel concerning dancing as an ideal way to prevent, and also to treat, the neurodegenerative diseases associated with mental problems.

In conclusion we want to stress that it is impossible to transfer into a paper the warm atmosphere, the enthusiasm and the exchangeas generated by the 2021 World Day of Older Persons in Košice, that included the contribution of Professor Anton Fabian and of Professor Oliver Racz (4,5).

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2. Gričar J.Minister for Seniors Appointment. Bull Eur Assoc Profs Emer 2021; 2(3): 51-52.

3. De Santo NG, Gričar J, Ehrich J. An appeal for the establishment of Ministries for Seniors in all countries of the European Union- Bull Eur Assoc Profs Emer 2022; 3(1)

4. Fabian A. Senior – More Than a Protocol of Life. Bull Eur assoc Profs Emer 2022; 3(1)

5. Rácz O. Are the "Oldest Old" Exceptions or Not? Bull Eur Assoc Profs Emer 2022; 3(1)

Professor Halima Resic awarded by Balkan Cities Association of Nephrology, Dialysis, Transplantation and Artificial Organs (BANTAO)

Natale G. De Santo
Malcolm Phillips
Editorial Board Members of the
Bull Eur Assoc Profs Emer

Prof. Emerita Halima Resić has been awarded by BANTAO for her distinguished contribution for BANTAO Association (Fig. 1). During her term the organisation grew by two members, and the General Assembly confirmed her proposal to make the BANTAO congress an annual event.

Figure 1

The main goal of BANTAO is to promote scientific and technical cooperation for renal diseases and artificial organs among cities of the Balkan Peninsula and with the international nephrology community.

The history started in 1993 at the time of the first Congress of the Macedonian Society of Nephrology, Dialysis, Transplantation and Artificial Organs (MSNDTAO) in Ohrid. Since then, after 28 years of growth, with the Balkan spirit connecting the members, it's membership consists of 10 countries: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Greece, Montenegro, North Macedonia, Romania, Serbia and Turkey.

Figure 2

The BANTAO initiative could not be diminished by wars, cruelty or hatred. It remains a growing institutional foothold and organisation and is a major scientific forum for Balkan nephrologists, giving them strong opportunities for communication, collaboration and shared growth. BANTAO remains as committed as ever and is still going strong.

Halima Resić (Fig. 2) is Professor of Internal Medicine-Nephrology in Sarajevo. She worked at the Clinical Centre University of Belgrade from 1972 to 1992 and in 1993 at the Marmara University of Istanbul. From 1994 to 1996 she took part in projects for refugees in Munich with the support of the the Ministry of Health of that city. From 1996 until 2019 Professor Resić worked at the Clinical Center University of Sarajevo, where she was head of the Clinic of Hemodialysis. In 2001 she obtained her PhD degree in Nephrology. She became a professor at the Medical Faculty of the University of Sarajevo in 2013.

Professor Resić has published around 200 profesional and scientific papers in relevant journals. She is an active participant in national and international congresses, and has been an invited lecturer in over 50 different international and national congresses.

Professor Resić has been President many organisations: the BANTAO Society, the Mediterranean Kidney Society, the Society of Nephrology, Dialysis and Kidney Transplantation in Bosnia and Herzegovina, and also of the Donors Network of Bosnia and Hezegovina. She is a member of ERA EDTA and ISN, and also member of the Committee of SRC by ISN.

In her career she obtained many international awards for her work in the field of nephrology including the *Mentorship Award* of the ISN (2021), *Pioneer Award of the ISN* for Eastern and Central Europe Region (2019), *ERA-EDTA Distinguished Fellowship* for actively helping the Association in pursuing its goals (2015), *Ambassador of the year Award – Global Kidney Academy* (2011). Halima Resic has been nominated by The International Academy of Sciencee and Arts of Bosnia Herzegovina (Figure 3).

Figure 3

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TOPICS OF THE CONGRESS

1. Academies, Emeriti and their Associations; 2. Aging; 3. Back to Learning; 4. Biodiversity; 5. Challenge of Fair Access to University; 6. Climate Changes and Negative Emissions; 7. Contribution of Professors Emeriti to Science; 8. Cultural heritage; 9. Engineering; 10. Europe; 11. History; 12. History of Medicine; 13. History of Science; 14. History of Surgery; 15. Human Capital of Age; 16. Linking the Needs of Children and Old-olds; 17. Management of Health Changes in our Century; 17. Mentoring; 19. Mental Health; 20. Migration; 21. Nature Protection; 22. Pandemics; 23. Philosophy; 24. Scientific Achievements through the Ages; 25. Space conquest; 26. Others.

ABSTRACTS PUBLICATION

As for the Athens Congress Abstracts, they will be published in a Supplement of *Archives of Hellenic Medicinee 2022*.

PUBLICATION OF PROCEEDINGS

The Proceedings of the Second EAPE Congress will be published in a book edited by the Society for the Propagation of Useful Books in Athens. Instructions will be emailed before the congress to all presenters of accepted abstracts.

SUBMISSION OF ABSTRACTS

The congress is open to presentations of EAPE members and their guests.
As for the tradition of the Founding Congress and of the First Congress the program will be arranged on the abstracts received by EAPE members and their guests. From October 15, 2021 to December 20, 2021 it will be possible to submit abstracts (220-250 Words) to be discussed at the Congress. Abstracts shall be submitted-online at www.emeriticongress2022.it

INSTRUCTIONS FOR ABSTRACTS ONLINE SUBMISSION

- Title in bold capitals
- Name in bold
- University & Department in italics (not in bold)
- Email address in italics (not in bold)
- Text of up to ***250 words but not less than 220***

EXAMPLE OF ABSTRACT FORM

GIVING OTHERS THE CHANCE WE HAD, THE CHALLENGE OF FAIR ACCESS TO UNIVERSITY

GIVING OTHERS THE CHANCE WE HAD, THE CHALLENGE OF FAIR ACCESS TO UNIVERSITY

Les Ebdon

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Studying at university remains a life changing experience for many young people today, but the opportunity is still not available for all who have the potential to succeed in higher education and the wish to do so. Barriers remain in virtually every country in the world. You are much more likely to go to university if your parents went or if they are rich. Often ethnicity, religion or socio-economic class determine your chances and in some countries where you are born or your gender remain important. In our increasingly knowledge based economies, this lack of access to higher education is not

only wasteful of talent but it is economically damaging. In a democracy, such blatant disregard for equity is also socially and politically damaging. Consequently many countries are now enacting policies to provide fairer access to higher education. This talk will draw on the author's experience, both as a University leader and a Government appointed independent regulator of 'Fair Access to Higher Education' in England. The scale of the problem and its root causes will be illustrated and global comparisons given. Some of the activities being promoted to provide fairer access and widen participation in higher education will be discussed. These will include the role of scholarships, grants, loans and fees and their effect on participation. The importance of raising both aspiration and achievement amongst school leavers will be illustrated, as will the importance of long term strategic outreach programmes. Opportunities for Governments, Universities, charities and retired academics to get involved will be outlined.

PRELIMINARY PROGRAM

Thursday April 28, 2022

Main Hall Grand Hotel Vesuvio
45 Via Partenope, Napoli

- **1.00 PM: Registrations**
- **2.30-4.30 PM: Session 1 (plenary) - Academies**
  Prof. Giuseppe Marrucci, Naples, *Accademia Pontaniana (1443)*
  Sir Adrian Frederic Melhuisc Smith, *The Royal Society London (1660)*
  Prof. Goffredo Sciaudone, Naples, *Società Nazionale di Scienze Lettere ed Arti in Napoli (1698)*
  Prof. Ortensio Zecchino, Ariano Irpino, *BioGem/Biology and Molecular Genetics (2006)*
  Prof. Christos Zerefos, Athens, *The Academy of Athens (1926)*
  Speaker to be nominated: *Italian Institute for Philosophical Studies (1975)*
- **4.30 PM:** Break
- **5.00-6.00 PM: Opening Ceremony**
- **6.00-6.45 PM: Session 2 (plenary) Special Lecture:** Patrick Berche, Académie de Médecin Paris, *Covid-19 Syndemic, a New Concept in Public Health*
- **6.45 PM: Session 3 (plenary): Special Lecture:** Riccardo Valentini, Director of the Impact Division of the Euro-Mediterranean Center on Climate change, *Climate change*
- **7.30 PM: Informal Getting Together**

Friday, April 29, 2022

Centro Congressi Università Federico II
36 Via Partenope, Napoli

- **8.00 AM: Registrations**
- **9.00-11.00 AM:** Hall A and Hall B - **Parallel Sessions 4 & 5: 16 Minilectures** (Each 13 min. + 2 min. for introduction of the Chairs)
- **11.00-11.20 AM:** Break
- **11.25 AM - 1.45 PM:** Hall A and Hall B - **Parallel Sessions 6 & 7: 16 free communications** (10 min. + 5 min. each)
- **1.30-2.45 PM:** Break
- **2.45-5.15 PM:** Hall A and Hall B - **Parallel Sessions 8 & 9: 20 free communications** (10 min. + 5 min. each)
- **5.15-6.00 PM:** Hall A - **Session 10 (plenary): Special Lecture**
- **6.00-7.30 PM:** Hall A - **Session 11 (plenary): Assembly**
- **8.30 PM: Social Event**

Saturday, April 30, 2022

Centro Congressi Università Federico II
36 Via Partenope, Napoli

- **9.15-10.00 AM:** Hall A **Session 12 (plenary) Special lecture:** Dennis V. Cokkinos, Biomedial Research Foundation Academy of Athens, Emeritus Professor of Cardiology, Athens, *Cardiology in the 21st Century.*
- **10.00-11.15 AM:** Hall A and Hall B **Parallel Sessions 13 & 14: 10 Minilectures** (13 min. + 2 min. introduction and comment from moderator)
- **11.15-11.35 AM:** Break
- **11.35 AM - 1.45 PM:** Hall A and Hall B - **Parallel Session 15 & 16: 26 minioral presentations** max 4 slides in 7 min. (+1 min. to moderators) + 2 min. 1 question or comment
- **1.45-2.00 PM: Final Session (plenary): The third EAPE Congress**

INSTRUCTIONS TO AUTHORS

The Bull Eur Assoc Profs Emer is a multidisciplinary journal fostering the idea that the vocation for research and teaching is for life and protecting full use of the human capital of professors emeriti.

The Bulletin adopts the Vancouver style. Authors are invited to visit the website of the Association and read the last issue. Manuscripts shall be in good English in Word, font 12, with good illustrations and shall be emailed to the editor in Chief, Natale Gaspare De Santo MD.

• Email: nataleg.desanto@unicampania.it

Original manuscripts (Word file) around 900-1100 words shall include affiliation(s), email and phone numbers of the authors, as well as 5 keywords from the manuscript. Preferably titles should not exceed the length of 50 characters (spaces included). A portrait of the 1st author is required. 1 Figure and 1 Table (emailed on separate sheets) and a maximum of 6 references and a minimum of 3 are allowed. References must be numbered and ordered sequentially as they appear in the text. When cited in the text, reference numbers are to be in round brackets.

Manuscripts related to news about emeriti and their associations shall be limited to a maximum of 500 words, and up to 3 references; no portrait of the author is required, but 1 Figure or 1 Table can be added.

All manuscripts undergo editing.

At the end of the article number references consecutively in the order in which they are first mentioned in the text. For articles with more than 6 authors, list the first 3 authors before using "et al."; For articles with 6 authors, or fewer, list all authors.

JOURNALS

1. *Journal article published electronically ahead of print:* Authors may add to a reference, the DOI ("digital object identifier") number unique to the publication for articles in press. It should be included immediately after the citation in the References.

Bergholdt HKM, Nordestgaard BG, Ellervik C. Milk intake is not associated with low risk of diabetes or overweight-obesity: a Mendelian randomization study in 97,811 Danish individuals. Am J Clin Nutr 2015 Jul 8 (Epub ahead of print; DOI: *doi:10.3945/ajcn.114.105049*).

2. *Standard journal article*. List all authors when 6 or fewer; when 6 or more, list only the first 3 and add "et al." Abbreviate journal titles according to *Index Medicus* style, which is used in MEDLINE citations.

De Santo NG, Altucci P, Heidland A et al. The role of emeriti and retired professors in medicine. Q J Med 2014;107: 407-410

3. Committee on Infectious Diseases, American Academy of Pediatrics. Measles: reassessment of the current immunization policy. Pediatrics 1989; 84.1110-1113.

BOOKS and other MONOGRAPHS

1. Personal authors

Antier JJ. Jean Guitton. Milan, Paoline, 2002

2. Committee report or corporate author

World Health Organisation. Good Health Adds Life to Years. Geneva, WHO, 2012.

3. Chapter in book

De Santo NG. The priority: broadening the boundaries of paediatrics and turning basic science into cures. In Erich J, Corrard F, De Santo NG, ed. This I think should have priority in child health care services. Joachim Barke, Hannover 2018:69-71.

4. Agency publication

Committee on Infectious Diseases, Report of the Committee on Infectious Disease, 22nd Edn. American Academy of Pediatrics. Elk Grove Village, 19991; 319-320.

IINTERNET REFERENCES

1. Website

Plato. Laws.http://data.perseus.org/itations/um:cts:greek-Lit:tlg034,perseus-eng1:3.666 (accessed May 14, 2020).

2. Online journal article

De Santo NG. The Impact of Covid-19 on Education and Science Florence in the XIV century -after plague, famine, death and depopulation- generated Renaissance Scholars such as Filippo Brunelleschi, Giovambattista Alberti and Leonardo An Achievable goal for our Universities. Bull Eur Assoc Prof Emer 2020; 1(2): 19-20. (accessed 14 May, 2020)

EMAIL YOUR MANUSCRIPT TO

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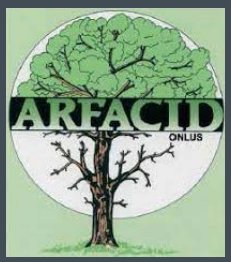

ARFACID ONLUS
Association of Social Solidarity and Promotion of
Studies on Cancer, Aging and Degenerative Diseases

President: Prof. Vincenzo Bonavita

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ISSN 2945-0381