

infections, which was similar to other studies.^{2,9} The high frequency of infections in our study could be attributed to high temperatures in Delhi, leading to excessive sweating and overcrowding promoting cross-infection in the family.

Pigmentary dermatoses constituted the third most common group of dermatoses in the elderly. Idiopathic guttate hypomelanosis is a common, benign pigmentary disorder related to ageing which mimics vitiligo that compels the patient to seek consultation. It was seen in 25.4% in our study, which is similar to other studies.^{3,10} However, Raveendra reported a higher frequency of 33% in his study.² The incidence of psoriasis in our study was 5.8%, while in various other studies, it ranged from 1% to 11%.^{3,11–13} Nearly 12% of patients presented with eczematous disorders, the commonest being asteatotic eczema. This incidence is slightly low as compared to other studies where it ranged from 11.9% to 58%.^{2,7,9} Immunological disorders were seen in 8% of our patients. The incidence in other studies ranged from 0.5% to 4.1%.^{1,14,15} The incidence of allergic dermatitis in our patients was 6.8%. This was mostly seen in the group using hair dye and mustard oil. Other studies reported an incidence ranging from as low as 1.5% to as high as 58.7%.^{5,16,17} This variation may be on account of regional, cultural, environmental and occupational differences.

In various studies, the incidence of bullous disorders ranges from 0.5% to 4.4%, while in our study, it was 1.3% with bullous pemphigoid being the commonest presentation.^{1,2,7,10} Trophic ulcer was seen in 8 (4%) cases in a study done by Raveendra.² A large number of geriatric patients are on a number of drugs for their comorbid conditions and hence are at higher risk for developing drug-induced dermatoses. The incidence of drug-induced dermatoses in our study was 1.8%.

Diabetes was the most common comorbid condition with an incidence of 49%. Its incidence in several other studies ranged from 9% to 32.5%.^{3,11,18} However, Nair and Vora reported the most common comorbid condition to be hypertension in 70.9% of their patients.¹⁸

Associated comorbid conditions such as hypertension and diabetes predispose the elderly to several dermatological diseases and we suggest that multispecialty, one-stop clinics are required for the elderly to minimize inconvenience and for expediting the management of multiple problems including those related to the skin.

Conflicts of interest. None declared

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Recommendations for a National Sleep Policy in India

The National Health Policy of India, revised in 2017, fails to address the critical issue of the requirement of adequate sleep for the population as a whole, which may influence the public health statistics of India. A comprehensive national sleep policy is a need of the day.

Impaired sleep and a high incidence of sleep disorders adversely affect adults as well as children. Inadequate and restricted sleep affects mood, cognition, decision-making ability and is a cause of obesity and increased cardiovascular mortality. Driving while being drowsy contributes to vehicular accidents. In such a scenario, India needs a national sleep policy with 5 and 20 years' goals in public health.

The National Health Policy of India, 2017¹ was revised after nearly 15 years (the last health policy was formulated in 2002). It aims to achieve the highest possible level of health and well-being for all citizens at all ages without placing anyone under financial constraint. The 2017 policy marks a shift in focus from selective to comprehensive primary healthcare and covers major issues of non-communicable diseases, mental health, geriatric health, palliative care and rehabilitative services. The major allocation of funds has been to primary healthcare. However, what it fails to address is the important subject of adequate sleep. The policy has overlooked the impact of sleep restriction, sleep deprivation and sleep disorders on public health and consequently its health implications for the nation.

India is a growing economy with a large population. The health outcome of lack of sleep in quality and quantity has not been paid much attention so far. Getting sufficient quantity and good quality sleep is quintessential for good health² and longevity. The recommendation for adults is at least 7–8 hours of sleep every night³ and for children 10 hours of sleep every night.⁴ However, the population does not get enough sleep. The prevalence of sleep disorders in India is high. A study has pegged the percentage of insomnia to be as high as 33% among adults in India.⁵ The impact of

sleep deprivation on health is deep and extensive. Daytime sleepiness in adults can lead to reduced productivity. Sleep deprived people are less effective in making quality decisions and are more likely to experience distress,⁶ develop obesity and are more likely to get coronary heart disease.⁷

Drowsy drivers can cause fatal accidents.⁸ Insufficient sleep in schoolchildren hampers their mood significantly,⁹ and causes daytime behavioural impairments.¹⁰ Even a small amount of sleep loss produces measurable outcomes. For example, if only 5 hours of sleep is provided for 4 consecutive nights, it impairs task performance to the same degree as a blood alcohol level of 0.6%.¹¹ First, awareness about sleep disorders is abysmally low in the country, which affects treatment-seeking behaviour. Second, any intervention in this area will lead to a large impact. We recommend a national sleep policy to address the following aspects.

1. Increase in awareness of the general public regarding importance of sleep in health and disease by creation of a comprehensive plan for dissemination of information using mass communication and through public lectures. The adverse effect of electronic devices on sleep, including the harmful effect of blue light on circadian rhythm must be highlighted.
2. Establishment of a regulatory body to determine adequate work hours.¹² Strict guidelines to be created, especially for shift workers in surface transport and aviation industries, hospitals, armed forces, law enforcement and every sector that needs shift work. There should be a provision for deterrence.
3. The perils of drowsy driving must be elucidated for the public. A module on drowsy driving may be made mandatory before a driving licence is issued. The continuous driving time should be subjected to regulation as well as maximum time on wheels in a defined period of time should be fixed.
4. Training of healthcare personnel must be ensured, particularly in primary health centres, to ensure early identification of sleep-related disorders and referral to higher centres for management. Subsidized professional and technical education on sleep should be provided in government institutions.
5. The priming of medical students towards importance of sleep must begin early, i.e. during training years. This calls for inclusion of sleep medicine-related curricula in undergraduate and postgraduate medical courses.
6. The availability of good quality equipment related to diagnosis and treatment of sleep disorders must be ensured. To meet this end, higher depreciation in equipment related to sleep medicine, and tax incentives for import of equipment should be provided.¹² Establishment of sleep centres must be facilitated, which may include initiatives such as provision of tax rebate. Insurance companies must provide coverage for diagnosis and treatment of sleep disorders.
7. An expert body should be established to identify key areas for sleep research for India. Setting 5 and 20 years' goals in public health is important. Increase in government-sponsored research funding in sleep in both public and private sectors is required.

Conflicts of interest. Professor Hrudananda Mallick is President of the Indian Society for Sleep Research and President of Asian Society of Sleep Research.

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Salt-restriction and adequate iodine consumption: Dual burden or twin-opportunity?

Iodine deficiency disorders (IDD) have been identified as one of the top micronutrient deficiencies. India's National Iodine Deficiency Disorder (IDD) Control Programme has been successful in achieving the optimal median urinary iodine concentration (mUIC) in the population at the national and zonal levels.¹

The epidemiological transition ratio ranges from 0.16 to 0.74, across the states of India,² which signifies the shift in pattern from communicable to non-communicable diseases (NCDs). With the launch of the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS), a comprehensive initiative to control NCDs has been taken by India. India is at a turning point where the iodine adequacy must be interpreted in the background of the global target of 30% relative reduction in mean population intake of salt/sodium by 2025,³ the major vehicle of iodine in India.

Paradox or two sides of the same coin?

High salt intake has been associated with increased risk of cardiovascular diseases (CVDs).^{3,4} At the same time, salt has been universally accepted and promoted as a vehicle for iodine delivery to the masses in many countries including India.^{5,6} The iodization level of 20–40 mg/kg in salt at production, the standards prescribed worldwide, is based on an average salt intake of 10 g/day at the population level, which may have changed. The Food Safety and Standards Authority of India (FSSAI) mandates an iodine concentration of >15 ppm in salt at the distribution level. The mUIC