Elderly patients more frequently and commonly suffer from gastrointestinal ADR and from the clinical consequences of NSAIDs use. Underreporting of the gastrointestinal events by patients is due to

T ose de-addicted were the patients of chronic pain nature, in which su f cient time was available for counselling regarding the ill e f ects of alcohol also patients were counselled regarding adverse reactions due to concurrent use of alcohol along with NSAIDs. T e smoking/tobacco de-addiction was also attempted, but ours being rural region of central India it was continued on another platform.

Type of NSAID	Diclofenac (100%)	454 (39.40%)	432 (37.5%)	177 (15.36%)	89 (7.72%)	1152 (39.76%)
	Ibuprofen (100%)	473 (42.34%)	365 (32.67%)	131 (11.72%)	148 (13.24%)	1117 (38.55%)
	Aceclofenac (100%)	243 (66.75%	74 (20.32%)	14 (3.84%)	33 (9.06%)	364 (12.56)%
	Etoricoxib (100%)	57 (18.12%)	76 (51.0%)	15 (10.06%)	1 (0.67%)	149 (5.14%)
	Indomethacin (100%)	15 (31.91%)	23 (48.93			

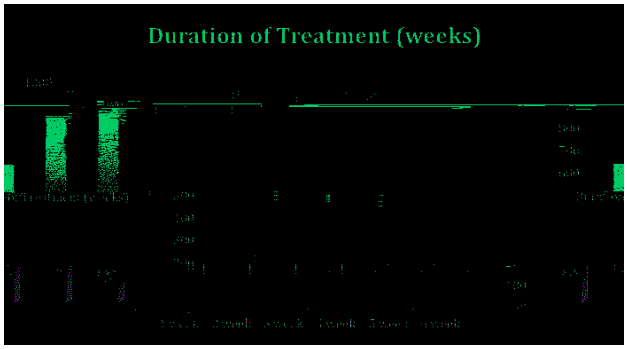

Figure 1: Duration of medications used.

Grade I	Dyspepsia, Nausea, Gastric irritation, GERD, Epigastric discomfort VAS <6	Withdrawal of offending NSAIDs + Sucralfate
Grade II	Vomiting, Epigastric pain VAS >6, diarrhea, Colitis	Required added medication (Misoprostol) to treat Gastro intestinal adverse effect
Grade III	Gastrointestinal bleeding, Melena, Hematemesis, Gastric ulcer and perforation	Required admission and Intervention in form of Gastroduodenoscopy, Surgical intervention

Table 8: Grading and treatment of gastro-intestinal adverse e f ects.

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