

## Frailty: Watch Ageing, Not the Age

With global improvement in life expectancy, India too has seen a jump from 49.7 years in 1970–1975 to 68.7 years in 2012–2016,<sup>[1]</sup> the number of elderly population requiring surgical interventions too is on the rise and the trend is expected to continue. With better understanding of pathophysiology and vast improvements in technology enabling monitoring on one hand and minimally invasive surgery on the other, the outcomes have improved considerably, including in the elderly population. It is common knowledge to all perioperative clinicians namely surgeons, anesthesiologists, internists, pulmonologists, physiotherapists, and other specialists that ageing does increase the surgical risk. Sadly, even today, in most of the centers, the assessment of risk associated with age and subsequent decisions are based on the intuition or ‘gut-feeling’ of the team members. In the absence of a widely accepted objective scientific tool, the subjective opinion of the *most powerful gut* of the group prevails!

Conventionally, individuals 65 years and above are defined as elderly, though the evidence to make this assertion is not known.<sup>[2]</sup> That 65 is just an arbitrary number is known to us all having encountered *75-years young* and *61-years old* individuals in our personal as well as professional lives. Better understanding has made it possible to conclude that these two elderly individuals are *differentiated by multiple physiological variables peculiar to ageing but not to chronological age*. The concept has been named frailty. Frailty has been defined as an age related, proinflammatory, multi-dimensional state mediated by dysregulated and decreased physiologic reserve that results in diminished resiliency and increased vulnerability to stressors.<sup>[3-5]</sup>

The concept of frailty, having profound impact on outcome of ageing individuals undergoing invasive interventions, has now been widely accepted. Sadly, frailty assessment has not yet found place in routine surgical and anesthesia workup. Reasons are many, prominent among those being lack of proper understanding, training and consensus amongst the team members. Additionally, non-availability of a widely acceptable practical bedside clinical tool, time constraints and paucity of geriatric experts, when required, too contributed in making even enthusiasts shy away. As of now, there is lack of agreement on how to screen or measure frailty and except for age merely as a number, frailty as such does not figure in most of the risk scores.

Measuring frailty is time and resource intensive exercise, framing an actionable protocol acceptable to all concerned even more so. The arbitrary decisions based on gut-feeling while dealing with vulnerable elderly must give way to proper assessment of frailty and a care pathway, now that there is enough evidence to support such an approach. The narrative review by<sup>[6]</sup> in this issue of *Annals*, comprehensively informs, educates and guides us, not only about the concept of frailty, but also its assessment and application across full spectrum of perioperative management of an elderly patient.

The authors have suggested a stepwise plan for frailty assessment and management, based on available evidence and experience. However, a word of caution may not be out of place. Since there is no universally acceptable tool, units will have to initially devise their own pilots best suited to them, determined by the perceived requirement and available resources including a committed manpower.<sup>[7]</sup> It is possible that the anesthesiologists, as the perioperative physicians, may have to initially start the frailty assessment on their own without buy-in of colleagues or support of management. A simple assessment based on interviews of the patient and family, few tests involving patient activity and a detailed physical examination should help them classify patients into frail, mildly frail or non-frail, or similar expressions. Coupled with existing surgical risk scores in use by the unit, the calculated frailty class could be plotted to find association with short- and long-term outcomes and assess power of its predictability. Data speaks louder than words and there is every likelihood that buy-in and support would be forthcoming over a period of time. Assessing frailty is only half the battle won, the other half is willingness to invest in interventions to optimize the deficiencies found, often time consuming, and may include not only delaying surgery where feasible but even denying surgery if that be the conclusion of shared decision making.

Socioeconomic and cultural factors in Indian context may add additional challenges. We don't have to just fight poor literacy rates, lack of awareness, and financial constraints but misplaced beliefs like instances of pushing reluctant elderly parents, all with noble intentions, into surgical interventions by their next of kin for what they consider as their moral responsibility, at times even with a request

to underplay the proposed surgery! An unwilling and demotivated patient can undo all the efforts made!

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