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Frailty: Its Scope and Implications for Geriatricians

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With the aging of population, more older adults become frail and many become dependent or bedridden. Frailty is defined as a status of vulnerability to endogenous and exogenous stressors that increase the risk of negative health-related outcomes. Frailty is usually caused by the interaction between progressive age-related decline in physiologic systems and chronic diseases, leading to decreased functional reserve capacities.[1] Frailty is generally considered a transition between successful aging and disability.[2]

What is the Scope of Managing Frailty for Geriatricians?

Disease to function-oriented focus: Frailty is a status of decreased functional reserve capacities.[1] Thus, frailty does not fit into the traditional medical hierarchy of 'health and disease'. Addressing frailty means a shift away from the disease-centered paradigm toward a focus on function.[3]

Comprehensive approach: Frailty includes social and psychological components in addition to physical dysfunction.[4] A longitudinal study showed that social frailty, defined as living alone, lack of social contacts, and lack of social support, was associated with the use of nursing care and contact numbers of health care professionals.[5] Cognitive dysfunction predicts physical frailty; moreover, physical frailty and cognitive impairment affect each other, resulting in worse outcomes.[6] Therefore, screening for frailty requires comprehensive geriatric assessment. Hearing impairment and visual disability are also risk factors for frailty.[7]

Multimorbid, complex status: Frailty is frequently associated with a multimorbid status. In the Cardiovascular Health Study, 9.7% of older adults with multiple morbidities were frail, while 67.7% of frail older adults had multiple morbidities.[8] To address frailty, a 'complex systems' approach is needed to address multidimensional processes and 'complex relation of biological and non-biological factors' on which frailty is based.[3]

Implications for chronic diseases: Frailty is an important consideration for geriatricians in the clinical setting, particularly with respect to treatment goals for chronic disease in older patients.[9] For example, guidelines from the European Society of Hypertension and the European Society of Cardiology recommend leaving decisions regarding antihypertensive therapy in frail older patients to the treating physician and considering treatment based on monitoring of the clinical effects of treatment and individual tolerability.[10] The American Geriatrics Society consensus panels recommend glycated hemoglobin levels between 7.5% and 8.0%, particularly in individuals aged >80 years who are at a high risk for frailty, comorbid conditions, and polypharmacy.[11] The decision to treat primary hypercholesterolemia with statins in Older adults aged 80 or more must be individualized and frailty status must be considered to decide on it as frailty may exacerbate adverse effects of statins.[12]

Why is Frailty Important to Geriatricians?

The management of frailty is the area in which the art of geriatrics is best practiced. Frailty has replaced the traditional concept of 'chronological age' with the more accurate and individually tailored 'biological age'.[1] In other words, frailty shed light on individualized care. Frail older adults are vulnerable and complicated, with care needs requiring skill and experience.

For this reason, frailty is a giant geriatric syndrome important to geriatricians; in this domain, the real value of geriatrics is shining brightly. Geriatricians differ from other specialists by providing specialized care for frail older adults. Geriatricians should champion the care of complex, vulnerable, and complex frail older adults.

Research and Implications

The Korean Frailty and Aging Cohort Study (KFACS), funded by the Ministry of Health, has been ongoing since December 2015. The KFACS is a multicenter, longitudinal study, with a baseline

survey conducted in 2016–2017 and a 2-year follow-up survey underway. The KFACS aims to identify risk factors for adverse outcomes associated with frailty and preventative measures in community-dwelling older adults.

The final goal of the research is to increase knowledge for the diagnosis and management of frailty for implementation in clinical practice to reduce disability and dependency of frail older adults. KFACS data revealed discrepancies in the prevalence of frailty scales.[13] Additionally, the risk of frailty was associated with limited contact with friends,[14] anorexia,[15] long sleep latency or long sleeping duration,[16] high sodium intake,[17] and low self-rating of health.[18] The KFACS dataset and laboratory findings are available to extramural researchers.[19]

CONFLICT OF INTEREST DISCLOSURES

The author claims no conflicts of interest.

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