

EDITORIAL

FRAILTY SCREENING COMES OF AGE

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In 2013 a consensus meeting of 6 societies (IAGG, EUGMS, AMDA, IANA, AFAR and SCWD) called for screening by health professionals of all persons 70 years and older for frailty (1). Whether or not this approach was feasible or useful has been questioned (2). This question has now been answered in the resounding affirmative by a large study from the Toulouse Gerontopole on their Geriatric Frailty Clinic (3). This study demonstrated that general practitioners can screen for frailty and when these frail persons are referred for a full geriatric assessment, a variety of treatable conditions are identified.

The concept of physical frailty as a precursor for disability was identified by Fried et al (4, 5). Since then numerous studies have shown that frailty is highly predictive of a variety of poor outcomes (6, 7). The study from the Gerontopole represents the first study showing that aggressive management of frailty can potentially reduce that progression to disability and other negative outcomes.

The causes of frailty are multifactorial requiring a interdisciplinary geriatric group to optimally identify and treat the frail individual (8, 9). A major cause of frailty is sarcopenia (10, 11). There is increasing evidence that aerobic and resistance exercise will successfully improve this aspect of frailty (12, 13). In addition, a high protein diet (or supplementation) also appears to have some utility (14). Persons with sarcopenia are at high risk of falls and should also be screened with the Toulouse-St. Louis University Minifalls Assessment and have a focused treatment on other falls risk factors (15). A number of pharmaceutical agents, such as selective androgen receptor molecules, are under development for treatment of sarcopenia, but the evidence for their utility is limited (16, 17).

The other major cause of frailty is the anorexia of aging, leading to protein energy malnutrition (18, 19). Screening for anorexia and being at risk for protein energy malnutrition can be effected with a combination of the Simplified Nutrition Assessment Questionnaire (SNAQ) and the MiniNutritional Assessment (MNA)(20-23). Utilization of the “MEALS-ON-WHEELS” mnemonic to identify treatable causes of anorexia, together with caloric supplements between meals are readily available treatment strategies (24, 25).

The other component of frailty is fatigue where depression is a major treatable component (26). Other causes of fatigue include sleep apnea, anemia, vitamin B12 deficiency, hypothyroidism and Addison’s disease. Finally, inappropriate

polypharmacy often decreases function in older persons and a careful review of medicines can lead to an improvement in frailty (27, 28).

The FRAIL questionnaire has now been well validated in multiple populations (29-31). It consists of 5 simple questions and can be answered before a physician visit. Simple approaches such as this make it easy for health professionals to rapidly screen for physical frailty.

Finally, it should be recognized that there is increasing evidence that cognitive decline acts synergistically with physical frailty to accelerate the trajectory to disability (32-36). This concept of “cognitive frailty” or “the frail brain” is becoming well recognized. The Toulouse Gerontopole had the prescience to include a screen for cognitive defects in their screening questionnaire (37-40). This will markedly increase the value of future studies from this group as they validate the utility of general practitioner screening for frailty and early cognitive decline.

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