Tidsskriftet Tidsskrift for Den norske legeforening

When older people become sick

INVITERT KOMMENTAR

SIRI ROSTOFT

srostoft@gmail.com
Siri Rostoft PhD, specialist in internal medicine and geriatrics, senior consultant at the Department of Geriatrics, Oslo University Hospital, and professor at the Institute of Clinical Medicine, University of Oslo.
The author has completed the ICMJE form and declares no conflicts of interest.

Assessing frailty is important for determining the most appropriate evaluation and treatment when older adults are hospitalised.

Older, hospitalised patients living with frailty have an increased risk of complications. Assessing frailty is therefore an important factor in decisions regarding evaluation and treatment (1, 2). In the study published in this edition of the Journal of the Norwegian Medical Association, Goll et al. examined the prevalence of frailty in the emergency departments at Tønsberg and Tromsø in Norway over the course of one week (3).

The term *frailty* refers to older adults with a heightened risk of adverse outcomes, such as complications from illness and treatment, death and the need for nursing home care (1). Frailty in the emergency department is a predictor of longer hospital stays, functional decline, readmission and mortality, and has a predictive value beyond the severity of acute illness (4). While frailty becomes more common with increasing age, the severity of frailty provides more information about individual risk than age alone. The Clinical Frailty Scale (CFS), developed by Rockwood et al., grades frailty on a scale from 1 to 9 in adults over the age of 65, with higher scores indicating more severe frailty (1). The scale is based on the idea that frailty is a continuum resulting from the accumulation of ill health and functional impairment. It provides an objective assessment of functional status, with specific scores for cognitive impairment. In clinical practice, the level of frailty, ranging from very mild to very severe, is more relevant than a dichotomous classification of frail/not frail.

In Goll et al.'s study, the majority of the 289 patients had a CFS score ≥ 4, indicating an increased risk of complications and death. The authors raise the question of whether early frailty assessments should be introduced in Norwegian emergency departments, in line with the consensus in Europe (5). The study did not investigate the

consequences of frailty, but the authors found that the incidence of delirium was higher in patients with increasing levels of frailty. Frailty can result from cognitive impairment, and cognitive impairment is a significant risk factor for delirium. The article does not emphasise that frailty should be measured at baseline (6). Functional status two weeks before hospitalisation should be assessed, and in acute situations, it is often necessary to obtain information about functional status from family members/caregivers.

> ***«Frailty should be measured in a stable phase. Functional status two weeks before hospitalisation should be assessed»***

Because frailty is a predictor of risk, the severity of frailty is important when determining treatment options and level of care. A meta-analysis of patients over the age of 55 who underwent acute laparotomy found that frailty, defined as CFS ≥ 4, increased the risk of 30-day mortality with an odds ratio of 3.84 (95 % confidence interval 2.90–5.09) (7). In the elective setting, frailty screening may lead to referral for a geriatric assessment and follow-up. The goal is to identify the underlying causes of frailty and optimise factors such as multimorbidity, medication use and physical function, with a view to enhancing the patient's reserves. Thus, frailty may, to some extent, be reversible.

Patients with severe frailty (CFS 7–9), which was the case for 12 % of the patients in this study, require assistance with most aspects of personal care and are often bedridden. They have minimal reserves and a high risk of complications and death, even from mild infections or minor surgical procedures (8). In my opinion, alarm bells should ring when patients with severe frailty are admitted to the emergency department. Is an advance directive in place? What are the patient's values and preferences? How should the ethical principles of non-maleficence and beneficence be balanced? As frailty increases, shared decision-making becomes even more crucial. Patients living with frailty are often excluded from clinical studies (9), and guidelines alone will not provide all the answers. The risk of adverse outcomes from illness and treatment is high. A great deal is at stake, and the patient's values and preferences should be properly taken into account in the decision-making.

> ***«To ensure personalised treatment for older patients, a common, objective language for frailty is needed in primary care and the specialist health service»***

Studies show that clinical descriptions of functional status are often subjective and imprecise (e.g. 'pretty fit and healthy'), such as when cancer treatment is discussed in multidisciplinary meetings (10). Among older patients, maintaining functional status is often prioritised over prolonging life. Frailty measurements can be repeated over time to identify functional decline during the treatment trajectory. To ensure personalised treatment for older patients, a common, objective language for frailty is needed in primary care and the specialist health service. The CFS is a promising tool, and it is encouraging to see it used in this study. Its use is increasing in Norway, including in national registries (the Norwegian Intensive Care Registry and the NorKog Registry)

and in home care services in Bærum municipality. Hopefully, objective frailty assessments in older patients will eventually become as routine as measuring blood pressure and pulse.

REFERENCES

1. Kim DH, Rockwood K. Frailty in Older Adults. N Engl J Med 2024; 391: 538–48. [PubMed][CrossRef]

2. Dejgaard MS, Rostoft S. Systematisk vurdering av skrøpelighet. Tidsskr Nor Legeforen 2021; 141. doi: 10.4045/tidsskr.20.0944. [PubMed][CrossRef]

3. Goll JB, Saga E, Johnsen B et al. Skrøpelighetsscreening hos eldre i norske akuttmottak. Tidsskr Nor Legeforen 2025; 145. doi: 10.4045/tidsskr.24.0504. [CrossRef]

4. van Dam CS, Trappenburg MC, Ter Wee MM et al. The Prognostic Accuracy of Clinical Judgment Versus a Validated Frailty Screening Instrument in Older Patients at the Emergency Department: Findings of the AmsterGEM Study. Ann Emerg Med 2022; 80: 422–31. [PubMed][CrossRef]

5. Moloney E, O'Donovan MR, Carpenter CR et al. Core requirements of frailty screening in the emergency department: an international Delphi consensus study. Age Ageing 2024; 53. doi: 10.1093/ageing/afae013. [PubMed][CrossRef]

6. Rockwood K, Theou O. Using the Clinical Frailty Scale in Allocating Scarce Health Care Resources. Can Geriatr J 2020; 23: 210–5. [PubMed][CrossRef]

7. Park B, Alani Z, Sulistio E et al. Frailty using the Clinical Frailty Scale to predict short- and long-term adverse outcomes following emergency laparotomy: meta-analysis. BJS Open 2024; 8. doi: 10.1093/bjsopen/zrae078. [PubMed][CrossRef]

8. George EL, Hall DE, Youk A et al. Association Between Patient Frailty and Postoperative Mortality Across Multiple Noncardiac Surgical Specialties. JAMA Surg 2021; 156: e205152. [PubMed]

9. van Marum RJ. Underrepresentation of the elderly in clinical trials, time for action. Br J Clin Pharmacol 2020; 86: 2014–6. [PubMed][CrossRef]

10. Lane HP, McLachlan S, Philip JAM. 'Pretty fit and healthy': The discussion of older people in cancer multidisciplinary meetings. J Geriatr Oncol 2019; 10: 84–8. [PubMed][CrossRef]

Publisert: 13. March 2025. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.25.0151