Letters to the Editor

Assigning “frailty”

Sir—I read the paper by Perera et al. and the accompanying editorial with interest as there is a need for geriatricians to recognise the treatments and outcomes for frail adults.

However, I have great difficulty in determining what cut score for the Edmonton Frail Scale (EFS) was used. It is not described in the article’s Methods section. There are two relevant references. Wolfson et al. have measured the correlation of the EFS against a Geriatrician’s Clinical Impression of Frailty questionnaire. Whilst they demonstrate a modest relationship (Pearson’s r = 0.64), they do not identify a cut point in the EFS above, or below, which a classification of ‘frail’ can reasonably be ruled in or out. Dasgupta et al. have found that EFS score ranges (≤3 or >7) have a reasonable relationship to the ability to predict which of an elderly cohort would not or would have post-operative surgical complications. But this is scarcely a reference against a ‘gold standard’ for identifying frailty, and again the statistical power of the association is poor with receiver operator curve ‘area under curve’ data of 0.69 for all complications and 0.65 for cardiac complications.

So, while there is an association for the EFS with other measures of frailty, I cannot apply these data to any other population of elderly because the key defining criterion is not given.

Conflicts of interest
None declared.

References

Response to: Assigning "frailty"

Sir—We thank Dr Chalcroft for his comments relating to our paper [3]. The categories of the Reported Edmonton Frail Scale (REFS) to determine frail and non-frail patients were reported under the sub-heading of ‘Data Analysis’ in the Methods section of the paper. The cut-off scores to determine frailty remained the same as those used in the original Edmonton Frail Scale [4] with 0 not frail (0–5) and apparently vulnerable (6–7) making up the ‘non-frail’ group and the mildly frail (8–9), moderately frail (10–11) and severely frail (12+) making up the ‘frail’ group. The groups were combined in order to maximise the power of the data to find differences, particularly when undertaking survival analysis to determine key outcomes (stroke, haemorrhage, death).

The concept of frailty is a hotly debated area. Although its use for identifying vulnerable patients is unquestioned, a clear definition that captures the social, physical and psychological changes associated with frailty has not been developed yet. The multidimensional nature of frailty and the struggle to untangle it from other concepts such as disability and comorbidity make the development of a scale to measure the syndrome a difficult task [1]. However, in order to investigate frailty and its influence on patient management, studies are restricted to using currently available definitions.

We validated the REFS, an objective measure of frailty in hospital inpatients made by non-medically trained staff, against what we considered to be the ‘gold standard’ (i.e. The Clinicians Global Impression of Frailty (CGIF)), which captures the geriatrician’s point of view on frailty [2]. While the REFS (or CGIF for that matter) may not be a ‘gold standard’ measure of frailty per se, studies using REFS add value to the existing knowledge of frailty and its implications. The robustness and non-invasive nature of REFS allow it to be applied to other inpatient populations. Use of the same cut-off scores as described in our paper allows a comparison of frailty between patient populations.

Conflicts of interest
None declared.

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Letters to the Editor

Re: Preventing injuries and fatalities among older pedestrians

SIR—The paper by Romero-Ortuno and colleagues [1] is an interesting application of new technological approaches to potential problems outlined previously with traffic signals and older pedestrians in Ireland [2] and several other jurisdictions. The emphasis on pedestrians is also consistent with the safety priorities of the World Health Organization on older people in traffic settings [3]. However, one challenge arising in the wider application of the findings of the paper is that only a small minority of pedestrian injuries and fatalities among older people occur at traffic signals [4]. Alteration or modification of traffic signals might at best be expected to have a modest impact on the number of injuries and deaths among older pedestrians. A more wide-ranging perspective on age-proofing the traffic environment for pedestrians is needed, such as that developed by the US National Highway Traffic Safety Administration in applying the safety zone concept to reducing crashes involving older (65+) adult pedestrians [5]. By developing procedures for defining pedestrian safety zones, and developing, implementing and evaluating a countermeasure programme in Phoenix, AZ and Chicago, IL, older pedestrian crashes were reduced by >46% in target zones. These zones were in general not related to traffic signals. Perhaps the authors’ finding that traffic signals fail to match the walking speeds of older pedestrians might more usefully be considered as a marker of a generalised insensitivity of the traffic environment to the mobility and safety of older people, and generate a wider debate on how we adapt our traffic systems to vulnerable road users in societies with increasing numbers of older people.

Conflict of interest
None declared.

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References

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