Reviewer’s report

Title: Treating frailty. A practical guide.

Version: 1 Date: 5 April 2011

Reviewer: Calvin Hirsch

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General Comments

As the authors point out, frailty has moved into the realm of a syndrome, with a validated phenotype, and the probability of frailty has been associated with the clustering or absolute count of associated conditions. This emerging syndrome needs recognition and interventions to prevent or mitigate it and its effects on disability and survival. The present manuscript, although extensively researched, thoughtfully prepared, and well written, does not provide a practical approach toward its treatment, but instead provides recommendations for just plain good medical care of the older person, frail or not. None of the recommendations are geared specifically for the prevention or treatment of frailty per se, and the efficacy of these interventions for the prevention of frailty either is unknown or not presented by the authors. In summary, there is an unfortunate disconnect between the Background section which defines frailty, and the subsequent recommendation in the Discussion. It is therefore recommended that the authors either refocus their manuscript on ideal (but unrealizable) geriatric care by community-based clinicians, or extensively revise their approach to frailty interventions as suggested in the comments that follow.

MAJOR COMPULSORY REVISIONS

Background

P 2, para 2, line 5: The “reversibility” of frailty underlies any rationale for its direct treatment, as opposed to primary, secondary, or tertiary prevention. A bit more elaboration on and discussion of the evidence supporting reversibility is warranted.

Discussion

P 2, para 1: A fundamental challenge in discussing interventions for frailty is the diversity of definitions that go beyond a clinician’s general gestalt. Although the authors acknowledge this lack of consensus, it would be helpful to expand on the basic ways in which frailty has been defined in the literature, i.e., by phenotype, by clusters of components, or by the number of elements in a large index.1 It also would be helpful to discuss how the classification of frailty can influence the clinician’s approach to interventions. For example, using Fried and Walston’s frailty phenotype as a guide, a clinician might target slow gait speed, weakness, and weight loss, but since the components are restricted to five, the interventions
inherently are limited. In contrast, someone utilizing an extensive frailty index might have a larger number of potential opportunities for intervention.

Principles of intervention

P 5ff. In developing their proposed interventions, the authors appear to deviate from frailty as a clear and distinct construct and focus instead on principles of good geriatric medicine. In this and the sections that follow, frailty as a term appears to be used in the old, generic, descriptive sense, rather than as an entity defined by strict criteria. This dilutes the stated purpose of the manuscript. It is all well and good to recommend GEM or CGA as the foundation of care, but few practitioners have the luxury of resource-intensive interdisciplinary teams, rendering this approach a bit pie-in-the-sky. “Interventions to reduce frailty” as presented seem dauntingly extensive and untargeted, and do not provide a useful, user-friendly template for community physicians. Rather than an “assess everything for everyone” approach, it perhaps would be more useful to offer guidelines focusing on primary, secondary, and tertiary prevention. For example, gait speed may be a good single-item screen for frailty, and primary prevention might be an exercise program or physical therapy for anyone whose gait speed drops to # 0.6 m/s. The authors refer to a useful assessment instrument that incorporates Fried et al.’s frailty phenotype (Additional File 1), but no further mention of this tool is made. The authors need to be explicit about what definition of frailty they use, and then use this definition as the basis for interventions. If a clinician uses this tool, and finds that a patient has 3 of 5 frailty criteria, what then? How should this information used? A figure containing representative flow diagrams could be helpful to readers, or at the very least be helpful to the authors in developing practical recommendations. Step 1 would logically be to confirm with additional screening the conditions recognized in the screen, and to create a differential diagnosis for each. Step 2 is to perform additional tests, if needed, and Step 3 is the development of feasible interventions for the patient, given existing comorbidities and resources. Etc.

The interventions in Table 1 represent good clinical care that is not unique to frailty, and many of the recommendations in the table in Additional File 2 refer the reader to exhaustive disease-specific guidelines that are neither user-friendly nor directed at the older patient. Again there is blurring between the treatment of frailty as a distinct condition and the provision of good medical care. The authors recommend a comprehensive screening (e.g., nutritional assessment, depression and cognitive screening, mobility assessment, etc.), but do not provide practical guidelines for how to apply this information to treat frailty.

The remainder of the manuscript addresses ancillary but important issues like adherence, case management, care coordination, etc. None of this is unique to frailty, but nearly all entails a level of interdisciplinary care beyond the reach of most clinicians and academic medical centers.

MINOR ESSENTIAL REVISIONS

Additional File 2
The authors do not give a reason for selecting the medical conditions in the table. Some clinicians might be insulted to be referred to the NICE guidelines to learn how to treat them, and wonder what the relevance is in an article on frailty. I was surprised that under “Vulnerability to Health Outcomes” the authors mentioned medication review without referring to the Beers Criteria of medications to avoid or minimize.2

References


Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

I declare that I have no competing interests.