



EDITORIAL

Is it useful to assess patient frailty upon admission to the Intensive Care Unit (ICU)?[☆]



¿Resulta útil evaluar la fragilidad de los pacientes al ingreso en la unidad de cuidados intensivos (UCI)?

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In this issue of *MEDICINA INTENSIVA* we publish an interesting research on the prevalence of frailty in patients over 65 years old (FRAIL-ICU) that amounts to 35%,¹ and its direct impact on mortality, especially 1 month and 6 months after ICU discharge.

Probably some readers will wonder what sense does it make to measure frailty at the ICU, what the profile of these patients should be, and what the utility of all this may be?

In an era defined by the necessary efficiency of the healthcare system with more and more elderly patients being admitted to ICUs, more complexity and comorbidities, worse prior functional statuses and therefore, frail and vulnerable, the initial assessment of these patients has become more and more necessary. And yet there is still uncertainty about the mortality results and quality of life of this subgroup of patients, which is why we need objective predictive

tools to help us decide what patients will benefit the most from the ICU stay, and who won't.²

Are the traditional criteria based on the patient's age, will, severity, prognosis, quality of life, presence of comorbidity, etc. any good anymore?

Are we convinced about not making positive discrimination by admitting patients without a clear benefit... or negative discrimination by denying admission to patients just because they are too old?

The severity of the disease that conditions the ICU admission and the patient's prior functional status, rather than age itself, are the key elements that determine the patient's overall mortality, and long-term vital prognosis and functional status.³

The traditional criteria used in younger patients, with fewer comorbidities and diseases of one system only and acute decompensations cannot be used with complex patients or patients with several diseases or frail patients, so new tools are needed and they need to be more adapted to the most prevalent type of patient with more multidimensional and holistic assessments of such patients.⁴

On the other hand, it would be interesting to know what health results are patients really expecting, above all complex patients and patients with multiple diseases, but... what results do patients care the most? Saving their lives at all cost is a good health outcome for them? Or maybe

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recovering an acceptable functionality and quality of life after the ICU admission would be a better outcome?

It is hard to know or predict what is best for this or that patient, and here the first step should always be knowing the patient's will after giving him honest information of what is at stake during an ICU admission. Patients admitted to an ICU with organ failures pay an expensive toll: the severe frailty that has a direct impact on the patient's recovery and return to his prior functional status.⁵

In line with recent international studies,⁶ the FRAIL-ICU study has opened Pandora's box on the impact frailty has (concept defined as a state of increasing vulnerability with poor resolution of homeostasis after a stressful event with an increased risk of adverse events, falls, delirium, and disability) on mortality, and whether it should be part of the decision-making process at admission and further therapeutic support.^{7,8}

Assessing frailty in elderly patients can be useful, but it is also important to assess it in young patients like the FRAIL-ICU says, especially in patients with chronic conditions, in those who have had prolonged prior admissions or in patients with criteria that contribute to frailty.^{1,6}

Frailty is associated with non-adjusted mortality, like the FRAIL-ICU study shows, and compromises the results and rehabilitation process of patients.^{1,6} That is why it may be useful to screen frailty in order to identify it early in young patients, be able to take preventive measures, help identify individual goals, and implement interventions to minimize the functional decline of critical conditions and reduce ICU stays.

Knowing about the existence of frailty can also help us adequate life-sustaining treatments at admission, since patients with frailty make more decisions of limitation of life-sustaining treatment (LLST)³ and early palliative care strategies even while at their ICU stay.⁶ Still, we need more studies on this regard to be able to determine the weight of frailty in the decisions of initiating or withdrawing life-sustaining treatments.

Frailty is useful together with other criteria for the assessment of those patients who may benefit the most from an ICU admission; it should be measured whenever patients show a previously deteriorated functional status, to implement an adequate action program capable of assessing treatment and the maximum level of organ support, not to fall into futile diagnostic and therapeutic situations, and ultimately to give the patient proper end-of-life care.

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