



# The Emergency Surgery Frailty Index (EmSFI) in Elderly Patients with Acute Appendicitis: An External Validation of Prognostic Score

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Dear Editor,

I read Fusario et al.'s article [1] with great interest, where the authors aimed to validate the Emergency Surgery Frailty Index (EmSFI) in older individuals (over 65 years old) undergoing emergency surgical procedures for acute appendicitis. From a very small sample population analyzed, authors concluded that those classified in the second EmSFI risk class had a higher rate of complications and that subjects aged 80 years and over had a higher risk of complications. They conclude that the EmSFI score is a useful and simple prognostic marker for frailty status in such a surgical setting. However, I got some concerns while reading.

Firstly, it is unclear how the validation has been performed. The validation process typically involves comparing the tool's results with established standards or reference measures to determine its validity and reliability.

Secondly, despite the authors stating that chronological age should not be equated with frailty, they presented all the results stratified by age rather than frailty status (under and over 80 years old). There is no consensus definition for who constitutes oldest-old adults; however, the oldest-old in developed countries refers to people ages 85 years or older [2]. No validated comprehensive geriatric assessment was performed in such sample population to differentiate between frail, pre-frail, and robust subjects. Again, there is some confusion in the text regarding the definitions of older, elderly, geriatric, and frail persons.

Thirdly the EmSFI, as previously described, looks more like a simple bedside risk score rather than an indicator of

frailty [3]. The EmSFI has a low accuracy as predictor of postoperative morbidity, while other tools including the Multidimensional Prognostic Index (MPI) are strongly associated with postoperative major complications [4].

Overall, I believe that surgeons do not necessarily need “specific and validated surgical risk scores to avoid unnecessary procedures or inappropriate treatments” in the geriatric (frail) population. This is not the purpose. Instead, they should collaborate with specialists in geriatric medicine with solid skill to detect the pre-frail and frail persons and give the best management. Surgery in the frail population, within a multidisciplinary team approach, should be directed at providing the tailored care at the lowest physiologic cost, beyond age itself.

## References

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