

EDITORIAL

DEFINING FRAILTY – THE HOLY GRAIL OF GERIATRIC MEDICINE

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Frailty is a major challenge facing the world as we move into the 21st century. But it is much like the fabled Holy Grail – something that we desperately want to get hold of, but can't quite grasp. Pel-Littel et al's review of frailty illustrates this dilemma; we do not yet know how to define frailty in a way which is operationally useful. Although we all know what we think frailty looks like, and manage 'frail' patients every day, a clear definition, which meets rigorous criteria of content, construct and criterion validity, remains elusive (1).

Frailty remains in the diagnostic category of being a syndrome – we can describe its constituent parts, but not the underlying cause. Frailty is associated with age and comorbidity, but not caused by them - frailty is not an inevitable part of old age nor of cumulative chronic disease. It is associated with functional decline, but it is generally agreed that frailty is a 'pre-disability state' – with the potential for intervention (2). How do we explain 'catastrophic functional decline' (3) if frailty is a gradual accumulation of insults? What about genetics – is frailty explained by the disposable soma theory (4) and programmed cell death? Then there are the biomarkers, including not only sarcopaemia and osteopaenia, but vitamin D, interleukins and C-reactive peptide (5, 6). These measures, along with the battery of frailty rating scores and other health measurement scales are describing the syndrome of frailty, but not diagnosing it. They may all be epi-phenomena, associated, but not causally related to frailty.

A definition is important because it allows diagnosis, and with diagnosis, treatments may follow (2). We may even be able to consider screening for and preventing frailty, but such measures cannot be justified until we have clearly defined the condition of interest. One commonly used working definition of frailty comes from Fried et al (7), comprising three or more of unintentional weight loss, self-reported exhaustion, weakness (reduced grip strength), slow walking speed, and low physical activity. Whilst useful in focussing research on frail older people, this definition is not readily applicable in the clinical setting; increasingly attention is being turned towards mobility limitation and falls as clinically useful markers of frailty (8).

So where do we go from here? We await with interest results from the bioscientists on the molecular biology of frailty, we

continue to describe the phenomenology of frailty, and we continue to promote comprehensive geriatric assessment as a method for managing frailty. But there are broader issues which also demand our attention – could it be that frailty is a consequence of modern society? In traditional society, whilst people became frail, they were cared for by their loved one's, such that any functional limitations were compensated for by their family's support. In contemporary Western society, the frail older person not only faces the challenge of functional limitation and the adverse outcomes we have ascribed to frailty, but also 'differential challenge' – the concept that those most in need are least able to access services. This might be because of lack of transport, lack of funding or many other social issues, which if addressed might render some current concepts of frailty redundant.

There is no doubt that frailty, whatever it is, will remain the core business of geriatricians, but will increasingly dominate the whole of society. Continued efforts are required to unravel this fascinating but puzzling phenomenon.

References

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