5th ERAS UK Conference 2015

Speaker: Elizabeth MacDonald,

Chairs: Tom Wainwright, Mike Scott, Nader Francis, Professor Ken Fearon

Challenges of preoperative optimisation in frail elderly

Audience: Should your frailty assessment kind of make a decision that your patient shouldn't go forward for surgery?

Elizabeth MacDonald: I think in the myth of the elderly one think we are very conscious of, that I don't think frailty should be reason not to include elderly in having surgery, but what it should be is to identify that they are a high risk group and you should optimise them first.

It may well be on the trajectory of frailty, there has been a lot of work on mildly, moderately and severely frail and when you're getting on to the severely frail patient then their life expectancy is probably 6 months to a year.

So I do think it is right to say this patient is on a decline and doing surgery is for the qualitative reasons and not because you can just do it. Anaesthetists and surgeons are a clever bunch and they can do just about everything. That's why grading frailty is very helpful to know what trajectory their own.

Audience: To follow up from that do you think we should be talking to patients and their families more about that type of trajectory before we put them through major surgery?

Elizabeth MacDonald Liz: Yes, I certainly think we should and I think in order to do that you have to measure frailty first and as I have said it is an unstable state so you have to measure it and you have to optimise and make sure you have them on the right trajectory and then very much we should talk to the families. I think they what to know about delirium and they what to know not being able to get back on their feet after surgery.

Thirty day mortality studies have shown that patients would rather not have surgery that was lifesaving if it meant they were going to be incapacitated after surgery and I don't think we have these explicit discussions enough with patients, partly because we don't have the facts and partly because we don't have the studies that actually show outcomes, I can tell them about mortality, but it is harder to tell them about longer term functional outcomes.

Mike Scott: To follow on from that does anyone here measure frailty scores for their patients either elective or emergency surgery

Attendee: Yes

Mike Scott: and what pathways are they in?

Attendee Frailty in older surgical patients, Weston General Hospital.

Elizabeth MacDonald That's the Weston General Hospital. I'm glad you put your hands up, that's my table

Mike Scott: we do it for fracture neck of femur but that's the only thing.

Elizabeth MacDonald: I think the other thing that is useful in patients that are coming back for repeat surgery is one of the thinks that is really interesting that if you have a measure of frailty from say last year and they come back for a repeat and the frailty is much worst and that tells you again where they are in trajectory. I think studies have shown that adding frailty assessment to your standard anaesthetic risk assessment actually does improve its procession.

Mike Scott: Ken I believe you have a question?

Ken Fearon: It's on the same lines as yourself mike, attacking at national level is obvious the comprehensive geriatric assessment is a time consuming resource consuming thing to deploy and I'm interested in your thoughts in the wider world, what do you see as the optimal screening to frailty assessment process?

Elizabeth MacDonald I think one of the advantages of being able to measure frailty, we are measuring lots of things but we know that in the over 65 population, 10% are frail and we know that in the over 65 population in surgery in general 25% are frail so if you look at you over 65's your distilling down to 25% are frail and within that frail group, you can distil further to about 10 12% are severely frail, so I think you can target a group that is not as big as you think it may be. And you can target your resource towards that. Quit a lot of comprehensive geriatric assessment can be in bedding in your day to day active the common things we are getting better at looking for and then starting to manage.

I was at a frailty meeting all day yesterday and the world of frailty, is becoming a diagnosis frailty and it will soon have a code of its own and I think we will have to address frailty in the group who are frail and actually give them the resource that we know at the minute improves they're outcome which at the minute is geriatric assessment but it doesn't need to be as time consuming as it looks if you start pre-operative and the same group follow it post operatively, one of the problems we have is lack of continuity of care of patients which might be fine if your fit and well, it's not fine if your old and frail. So when we see a frail patient before surgery, when I go and see them or the team go and see them after surgery we know all about them we have the jigsaw of them made already. So it doesn't become too time consuming after then.

Nader Francis: One final question?

Audience: That was a great talk, we are really keen to involve care of the elderly procedures in are surgical patients, but our care of the elderly physicians tell me that there is not enough of them, they can support us, they have three unfilled posts and this is a national picture and they can't help me for a couple of years and this is really important and I was wondering if you have any views on the national picture and how it would change?

Elizabeth MacDonald: Well this conference emphasised that yesterday, there was a lot of talk that there was not enough geriatricians to go round and that's true. So I think geriatricians need to play a role in embedding the skills you need to do comprehensive geriatric assessments and these skills are generic and everywhere in the hospital not just surgery.

I think you can embed skills to do geriatric medicine, that involves physiotherapists, nurses, occupation therapists and some of the things sound so simple but they are difficult to do in practice, but a lot of them are about looking at the core things that put people at risk if they're frail, and that's cognitive screening, fall assessment, nutrition assessment and skin assessment. All of these have well validated tools and well validated ways to deal with them. But I think what is important if you are going to screen for things you have to have things you can do about them.

And I think a lot of the ground work can be done within in units and it can be, I would spend your money not on a geriatricians but on a frailty nurse and then get the geriatricians to help train up the frailty nurses and guide these frailty nurses to become the real leaders for these frail patients. But I think it is a problem that all healthcare are going to really struggle with and I think we have developed services for single organ pathology and we are now seeing a population that is multi morbid and frail and we kind of got a mismatch that is not there.

Mike Scott: I think it is really important because we know in elective surgery 80% of our complications are in the 20% of high risk surgical patients, when you look at the elderly we know those fit 90 year olds who we do anterior section on and they're home in a couple of days, but there's the frail elderly.

One thing we have just set up, I'm chairing the fracture neck of femur guidelines for ERAS we have an international group with people with expertise in rehabilitation geriatrics not just surgeons and anaesthetists we are trying to develop a multi modal pathway where surgeons are the guests fixing the bone, there's obviously some evidence based associated to that. But the whole journey is about optimising and risk scoring patients and getting their rehab right as I think that actually probability has more impact on where the patient goes after, than whether you use a general anaesthetic or a spinal, which seems to be what a lot of the arguments seem are about. Have you got any comments for that Liz?

Elizabeth MacDonald I worry slightly about separating the frailty out from the disease that the person has been brought in with. It's the same in cancer services and other services and I think the slight danger we might is someone will do a procedure or give a chemotherapy and go away again, and in fact the whole decision about whether that procedure or that chemotherapy is correct has to be taken in context with all the other bits of the person, and so there's a bit of people being keen, and I can understand to do the bit that is fixable and give the chemo and then say, well geriatricians can take away the patient, that's never going to work it's not sustainable thing.

I don't think it's right either because I think the decision making for these patients the person doing the surgery needs to be at the very centre of decision making for that patient, they need to take in all the aspects of frailty and all these deficits and making a decision and seeing what happens next, so I think it should be shared care myself, all surgery that has a high proportion of elderly patients should have someone like myself but more importantly some frailty nurses trained up to see that patient through the pathway for continuity.

Mike Scott: I totally agree with shared care, but what I'm trying to suggest is that the surgery is only one hour of the whole patient journey.

Elizabeth MacDonald: You're not entirely right, but the surgeon is actually the key person to help make the decision about the benefits' of that surgery in the context of frailty.

Mike Scott: Yes I totally agree.