# Frailty in emergency general surgery and the role of the perioperative physician/geriatrician

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The aging of the population is a fact, and with it, our surgical patients are becoming increasingly more complex and frailer. It is a well-known aspect of our practice nowadays, but its impact was not recognized until recently. The article by Pearse *et al.*[1] showed us that mortality in major abdominal/colonic procedures in patients over 69 years of age is significant, perhaps more than we wanted to believe. The issues around the need for better care for elderly patients undergoing emergency surgery were subsequently identified in the Peri-operative Care: Knowing the Risk NCEPOD document (2011).[2] In that report, the role of frailty has been highlighted by the authors and particular attention was given to multiple comorbidities/polypharmacy/cognitive and sensory impairment compromising the outcomes of these patients. The subsequent (2015) National Emergency Laparotomy Audit report[3] issued specific recommendations that patients over 70 undergoing an emergency laparotomy should have Input from specialist Care of the Elderly teams.

The "High-Risk General Surgical Patient: Raising the Standard" 2018 report[4] by the Royal College of Surgeons of England further enhanced the message, advocating for routine assessment of frailty and rigorous screening for neurocognitive disorders in this group of patients. They also emphasized the importance of much needed change on a managerial and organisational basis to that effect. The 2021 British Geriatrics Society position paper[5] stated clearly that all elderly and frail patients undergoing emergency surgery should be seen by a consultant geriatrician within 72 hrs from admission. The recent World Society of Emergency Surgery position paper on frailty assessment in emergency laparotomy[6] comes to echo and further support the recommendations, after a systematic assessment of the current literature. Multiple international societies have endorsed similar practices, with the most recent ERAS in emergency surgery guidelines[7] adding frailty assessment and early involvement of medical teams to the framework of enhanced recovery after surgery protocols. Despite all the above, the latest NELA report showed that only 31.8% of these patients receive this care currently in England and Wales.

What can geriatricians do for emergency surgery patients? The role is evolving and there are many different models of care. They provide comprehensive geriatric assessment (CGA) with a multidisciplinary team, ensuring early identification of frailty and high-risk patients. That leads to the prevention and/or treatment of medical complications proactively, which results in less morbidity and readmissions. They are also vital in other "softer" interventions such as advising and participating in the management of chronic conditions, intervening on polypharmacy, initiating and substantiating discussions on anticipatory care pathways. Overall, this approach helps optimize the functional recovery of the patient through a multidisciplinary team, coordinating care and discharge planning along with the allied health professionals/therapists. They work in partnership with the surgeons and anaesthetists for joint decision-making and collaborative person-centred care.

What do surgeons want? A complete answer to that question cannot be given, and answers may vary from surgeon to surgeon and from institution to institution. It would be fair to say though, that, in principle, surgeons want good overall outcomes, high patient satisfaction, low mortality and morbidity, and a low readmission rate. Other potential answers could include combined surgeon/geriatrician ward rounds and shared care, takeover of frail/unfit for surgery patients directly by medical teams at the front door with surgical consultations on demand, or takeover of patients by geriatricians once the surgical problem is confidently resolved but the patients have ongoing medical or rehabilitation issues. The models are not the same and every unit should strive to find a way to incorporate this multifaceted approach, based on available expertise and resources.

The literature clearly shows the need for a closer collaboration between surgeons and geriatricians/physicians in the management of older and frail emergency surgery patients. This clinical need has its own challenges, related to workforce, organisational struc-

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ture and above all the surgeons' own commitment to change what they do. In this recent survey that was endorsed by WSES,[8] the vast majority of surgeons asked agreed that frailty was a crucial factor for the outcomes of their patients, however only a very small percentage used frailty assessment tools. Dedicated pathways should be ideally provided to all elderly patients. Their implementation should not only be viewed as a cost-efficient solution but also as an alignment with what is considered standard modern-day practice.

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