

Frailty and the Surgical Patient



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Outline

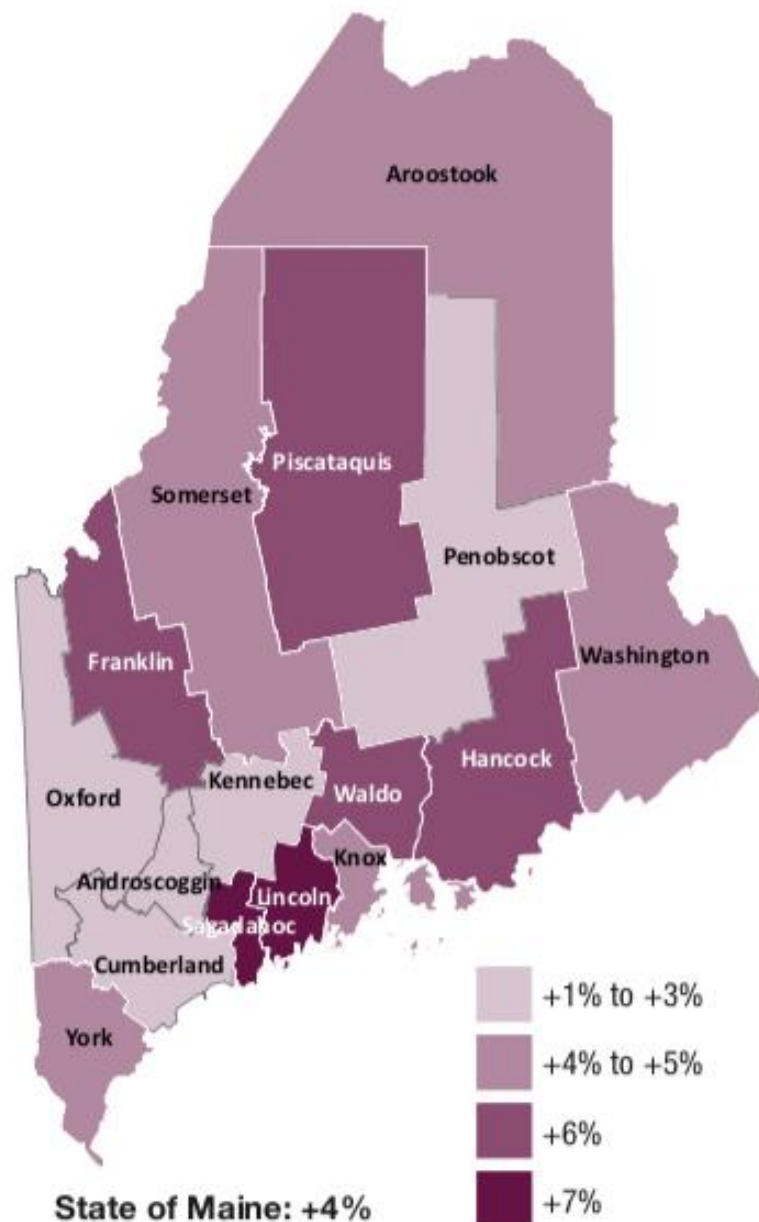
- Defining Frailty
- Frailty and Surgical Outcomes
- Risk Analysis Index
- Frailty and Cost

Surgery in Elderly Patients

- An aging populace mandates an increased use of surgical intervention in the elderly
- Surgical literature is replete with series reporting low mortality for complex procedures in older patients
 - patient selection

Aging Population

Change in percent of population over age 65 2000-2016



Cancer Admissions in Octogenarians

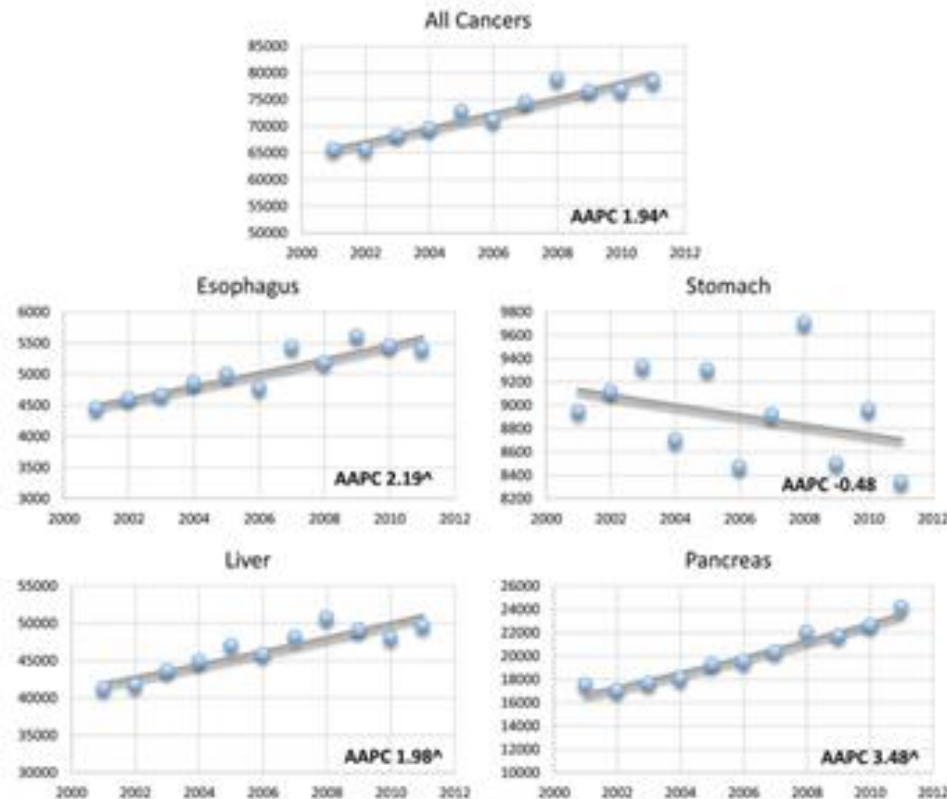


Figure 1. National estimates of admissions for cancer among octogenarians from 2001 to 2011 are illustrated according to the average annual percentage change (AAPC). Note that the slope of trend curve (^) represents a significant change over time ($P < .001$).

Major Cancer Resection in Octogenarians

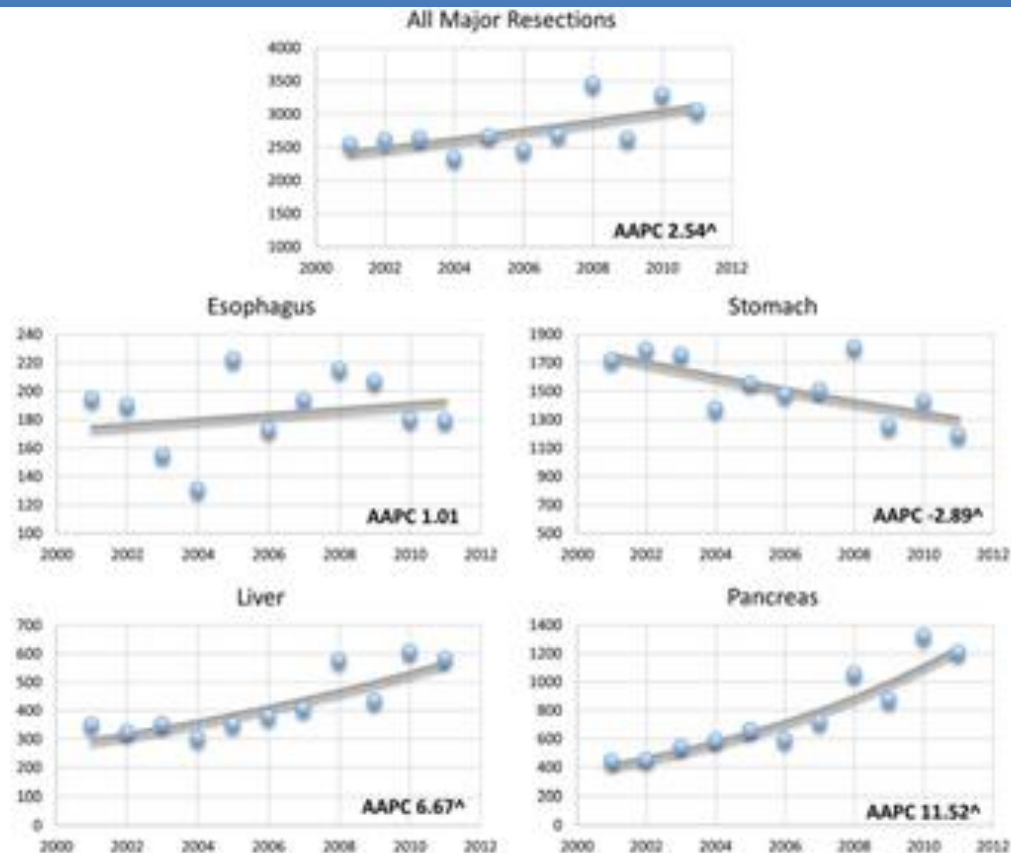


Figure 2. National estimates of operations for cancer among octogenarians from 2001 to 2011 are illustrated according to the average annual percentage change (AAPC). Note that the slope of trend curve (^) represents a significant change over time ($P < .001$).

Mortality after Major Cancer Resection in Octogenarians

Original Article

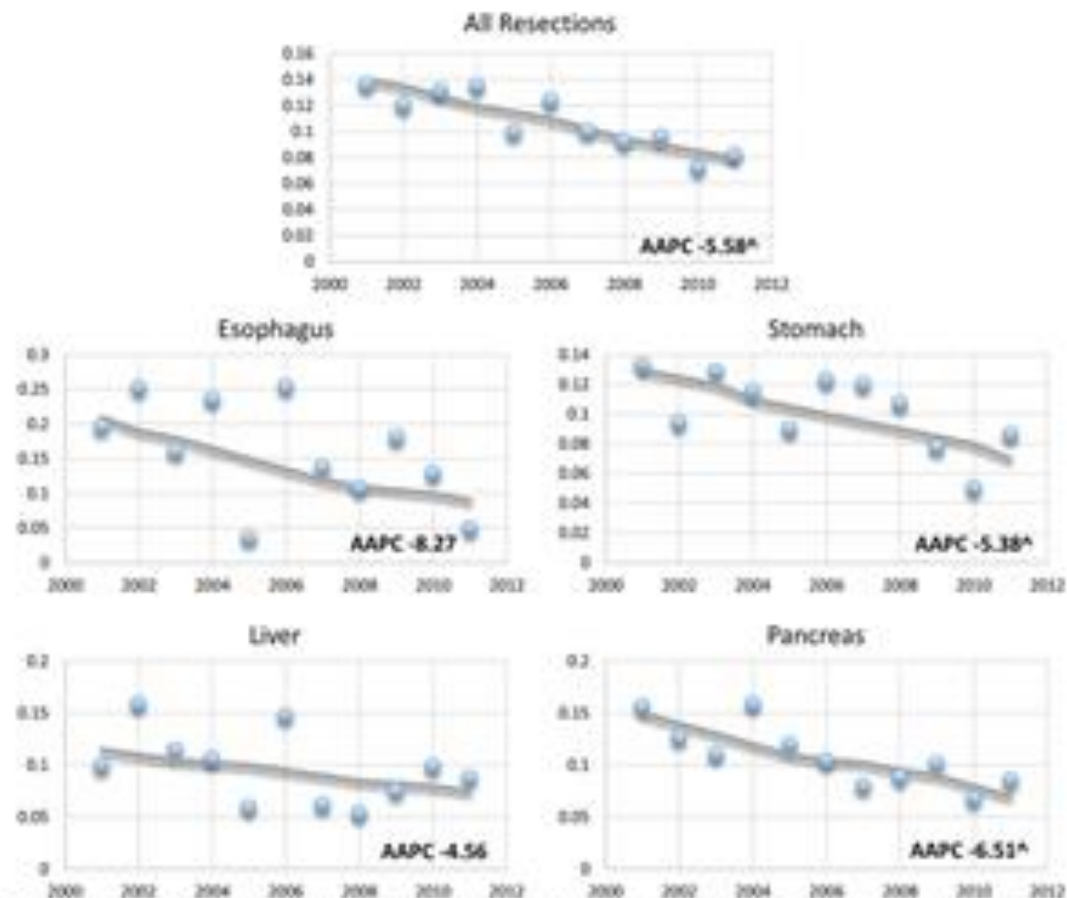


Figure 5. Mortality rates for cancer operations among octogenarians are illustrated according to the average annual percentage change (AAPC). Note that the slope of trend curve (—) represents a significant change over time ($P < .000$).

Frailty

- Decreased in physiologic reserve beyond that expected for normal aging
- No clear consensus on the optimal way to measure
 - Deficit accumulation- deficits across multiple domains
 - ADLs, mini-cognition test, and falls
 - Phenotypic- Speed to get up and go, grip strength, weight loss, exhaustion, decrease in muscle mass, and decreased physical activity

Frailty Indices

- Canadian Study of Health and Aging Frailty Index
- Comprehensive Geriatric Assessment
- Comprehensive Assessment of Frailty
- Groningen Frailty Index
- Edmonton Frailty Score
- Hopkins Frailty Score
- Fried Frailty Score
- Deficit model frailty indices
 - Modified Frailty Index and Risk Analysis Index

Frailty and Surgery

- Research tools have unclear real world implications
 - Small heterogeneous studies
- Understanding of the impact of frailty on the surgical patient is imperative
 - Patient selection, counseling, and modification of risk factors

Presented at the Academic Surgical
Congress 2016

Impact of frailty on surgical outcomes: The right patient for the right procedure



Catalina Mosquera, MD,^a Konstantinos Spaniolas, MD,^b and Timothy L. Fitzgerald, MD,^a
Greenville, NC

We hypothesized that increasing frailty would be associated with mortality, morbidity, and length of stay for complex surgical procedures

Materials and Methods

- ACS-NSQIP Participant Use Files from 2005 to 2012
- Patients undergoing high-risk procedures
 - Colectomy, esophagectomy, pulmonary resection, pancreatectomy, cardiac surgery, gastrectomy, nephrectomy, endovascular abdominal aortic aneurysm (AAA), and lower extremity bypass

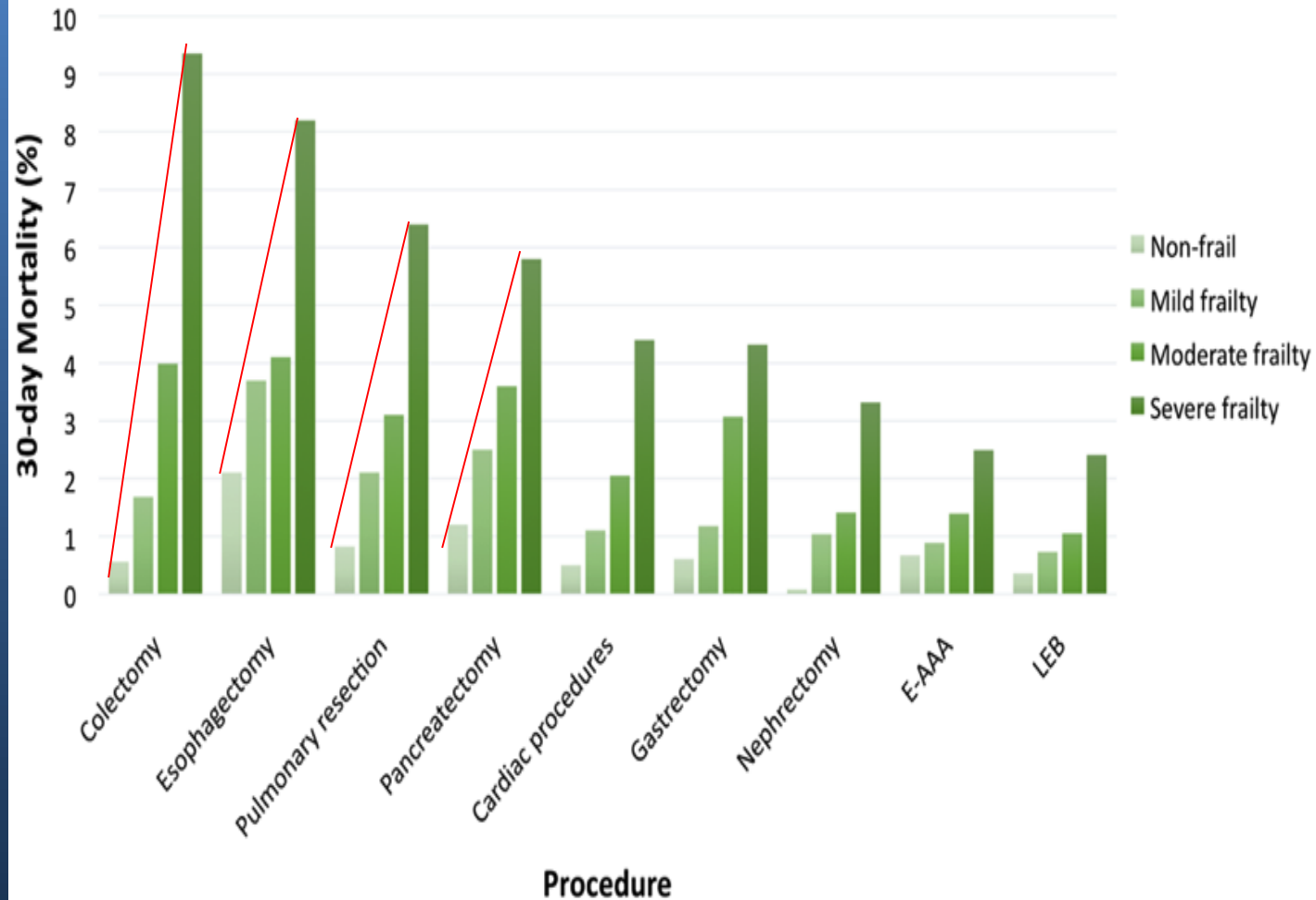
Materials and Methods: Frailty Measure

- Velanovich
 - 11-item frailty index derived from the CSHA-FI
 - Designed to analyze data from the ACS-NSQIP
 - Classification
 - Non-frail- 0
 - Mild- 1
 - Moderate- 2
 - Severe- 3 or more

Results: Mortality

Age		p value	Odds Ratio		
mean	72.17 (11.4) (23-89)	<0.0001			<0.0001
median	74				
Gender					
Female	1687 (1.6%)	<0.0001	Referent		<0.0001
Male	2309 (1.8%)		1.16		
Race					
White	3091(1.7%)	0.0191	Referent		
African American	410 (2.0%)		1.35		<0.0001
Other	145 (1.8%)		1.11		0.2307
Unknown	350 (1.7%)		0.93		0.2374
Procedure					
Colectomy	1766 (1.8%)	<0.0001	Referent		
Lower Extremity bypass	811 (1.44%)		0.32		<0.0001
Gastrectomy	224 (1.3%)		1.15		0.0557
Endovascular AAA	207 (1.3%)		0.32		<0.0001
Pancreatectomy	382 (2.3%)		1.40		0.0015
Cardiac Surgery	347 (2.6%)		0.82		<0.0001
Nephrectomy	59 (0.8%)		0.53		0.1063
Pulmary resection	108 (2.6%)		0.18		<0.0001
Frailty score					
0	441 (0.7%)	<0.0001	Referent		
1	1176 (1.4%)		1.65		<0.0001
2	1056 (2.1%)		2.75		<0.0001
≥3	1323 (3.8%)		6.01		<0.0001

Impact of Increasing Frailty by Procedure, NSQIP 2005-2012



Results: Complications

Age			Odds Ratio	
mean	65.6 (13.8)	<0.0001	0.99 (0.48)	<0.0001
median	67			
Gender				
Female	14,030 (13.2%)	<0.0001	Referent	
Male	17,661 (14%)		1.01	0.3005
Race				
White	23,969 (13%)	<0.0001	Referent	
African American	3,615 (17.5%)		1.53	<0.0001
Other	1,027 (3.2%)		0.97	0.4372
Unknown	3,080 (15%)		1.14	<0.0001
Procedure				
Colectomy	11,860 (12.5%)	<0.0001	Referent	
Lower Extremity bypass	5,465 (9.7%)		0.46	<0.0001
Gastrectomy	1,612 (9.3%)		0.78	<0.0001
Endovascular AAA	1,299 (8.2%)		0.44	<0.0001
Pancreatectomy	4,054 (24.3%)		2.30	<0.0001
Cardiac surgery	4,769 (36%)		3.02	<0.0001
Nephrectomy	1,027 (14.5%)		1.22	<0.0001
Pulmonary resection	554 (13%)		0.96	0.4615
Frailty score				
0	7,329 (10.8%)	<0.0001	Referent	
1	10,209 (12.7%)		1.18	<0.0001
2	7,271 (14.7%)		1.63	<0.0001
>3	6,882 (19.5%)		2.61	<0.0001

Results: Prolonged Length of Stay

Age			Odds Ratio	
mean	65.3 (14.1)	<0.0001	0.59	<0.0001
median	67			
Gender				
Female	2010 (3.1%)	0.4	Referent	
Male	2480 (3.1%)		1.11	0.0004
Race				
White	3215 (3%)	<0.0001	Referent	
African American	628 (5.3%)		1.90	<0.0001
other	231(4.1%)		1.45	<0.0001
Unknown	416 (3.8%)		1.44	<0.0001
Procedure				
Colectomy	2016 (3.5%)	<0.0001	Referent	
Lower Extremity bypass	791 (1.8%)		0.27	<0.0001
Gastrectomy	349 (4%)		1.21	0.0015
Endovascular AAA	82 (0.9%)		0.16	<0.0001
Pancreatectomy	743 (7.2%)		2.24	<0.0001
Cardiac Surgery	365 (5.8%)		1.12	0.0576
Nephrectomy	67 (2.17%)		0.65	0.003
Pulmonary resection	49 (2.5%)		0.63	0.0010
Frailty score				
0	1005 (2.5%)	<0.0001	Referent	
1	1379(2.9%)		1.30	<0.0001
2	938 (3%)		1.87	<0.0001
≥3	1151 (5%)		4.09	<0.0001

Conclusions

- Frail patients undergoing commonly performed high-risk procedures were significantly more likely to die
 - Magnitude of impact varied by procedure, with the starkest contrast seen for colorectal surgery
- Frailty was also associated with increases in complications and length of stay

Frailty Predicts Failure to Rescue after Thoracoabdominal Operation



Catalina Mosquera, MD, Juan M Bermudez, MD, Jessica L Evans, BS, Konstantinos Spaniolas, MD, FACS, Dougal C MacGillivray, MD, Timothy L Fitzgerald, MD, FACS

BACKGROUND: An association between frailty and mortality exists; we hypothesized this is secondary to failure to rescue (F2R).

STUDY DESIGN: Data were obtained from the NSQIP (2005 to 2012) for patients undergoing thoracoabdominal operations. Using the Modified Frailty Index, patients were classified as not (0 points), mildly (1 point), moderately (2 points), and severely (≥ 3) frail.

RESULTS: There were 962,913 patients included; a majority were non-frail (52.2%), followed by mildly frail (33.8%). Complications were noted in 15.3%, major complications in 9.5%, mortality in 1.8%, and F2R in 1.3% of patients. On multivariate analysis, increases in frailty were associated with an increase in the risk of major complications (mildly: risk ratio [RR] 1.51; moderately: RR 2.69; and severely frail: RR 5.63 compared with non-frail; $p < 0.0001$), and death (mildly frail: RR 1.84; moderately frail: RR 4.44; and severely frail: RR 12.4). On univariate analysis, older patients, males, those undergoing small bowel interventions, gastric operations, or other procedures, and the frail were more likely to experience F2R ($p < 0.0001$). On multivariate analysis, males (RR 1.07), those undergoing small bowel intervention (RR 1.91), gastric operation (RR 1.83), and other procedures (RR 2.43) compared with hernia repair were more likely to experience F2R. As frailty increases F2R increases (mildly frail: RR 1.48; moderately frail: RR 2.41; and severely frail: RR 4.41).

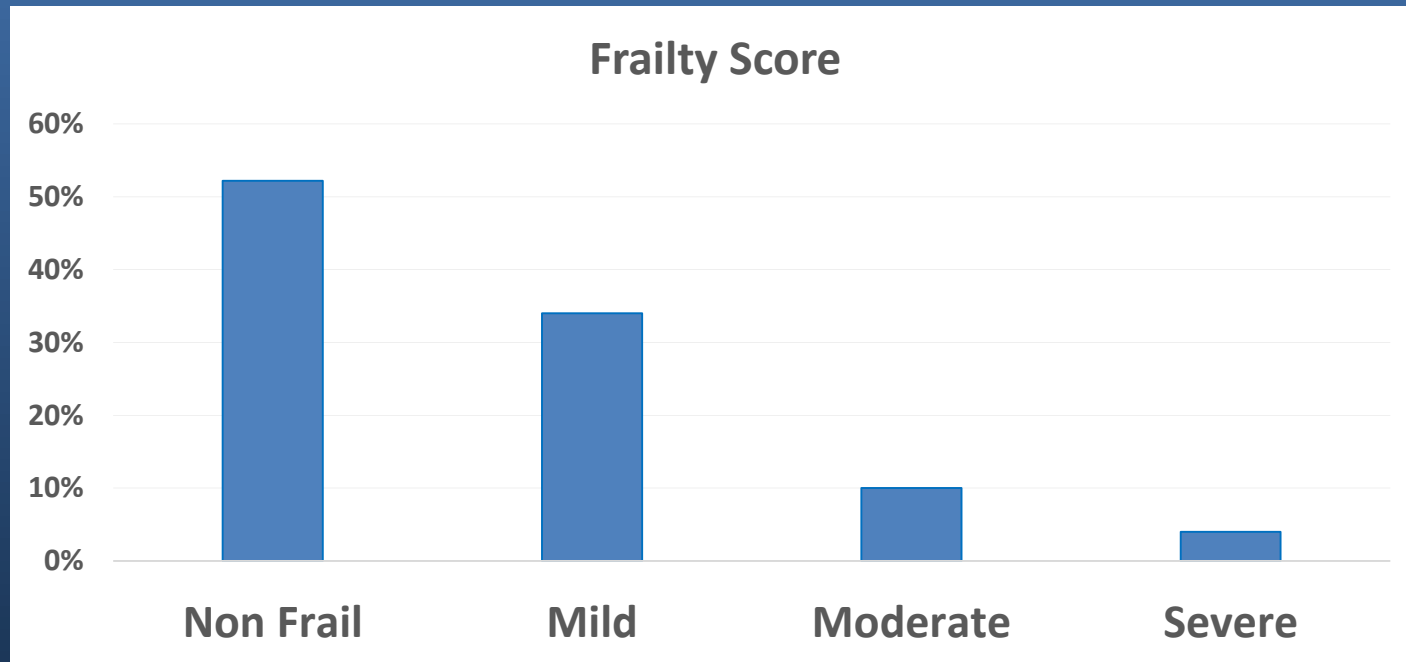
- Failure to rescue (F2R), is defined as death following a major complication.
 - Emerging quality metric concept
 - Benchmark for patient safety
 - Evaluates how well hospitals perform once a complications occurs
- We believe there this may be secondary to a association between frailty and F2R

METHODS

- Retrospective study
- National Surgical Quality Improvement Program (NSQIP)
 - From 2005 to 2012
- Patients undergoing thoraco-abdominal surgery
- F2R: Occurrence of mortality following major complication

RESULTS

Distribution analysis
Patients undergoing thoracoabdominal surgery, NSQIP 2005-2012
(n=972,914)

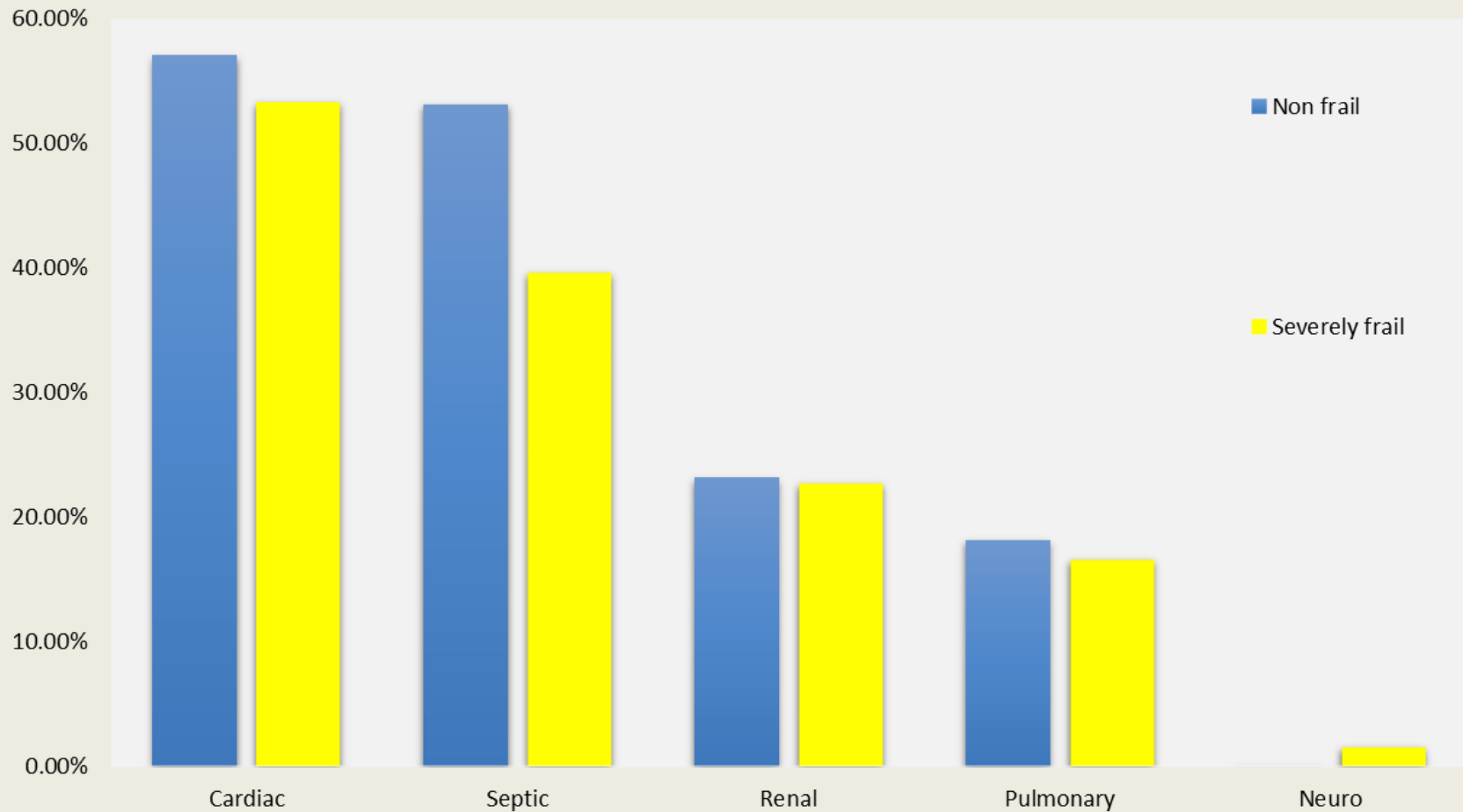


Factors associated with F2R, Patients undergoing thoracoabdominal surgery NSQIP 2005-2012

Characteristic	F2R (%)	Univariate (p)	Multivariate OR (95%CI), p
Age		<0.0001	0.96 (0.963-0.967), <0.0001
Race		0.6	
AA	13.51		
White	13.60		
Other	13.20		
Unknown	13.19		
Gender		<0.0001	
Male	14		1.07, (1.03-1.12), 0.0002
Female	13.02		Ref
Type of procedure		<0.0001	
Thorax	15.13		1.61 (1.40-1.84), <0.0001
Other abdominal	19.47		2.43 (2.17-2.72), <0.0001
CV	12.07		0.86 (0.77-0.96), 0.0097
Gastric	14.13		1.83 (1.62-2.07), <0.0001
HPB	9.46		1.10 (0.98-1.24), 0.08
Small bowel	16.55		1.91 (1.71-2.13), <0.0001
CRS	13.44		1.51 (1.36-1.68), <0.0001
Hernia repair	9.0		Ref
Frailty Index		<0.0001	
0	5.82		Ref
1	11.17		1.48 (1.39-1.58), <0.0001
2	17.60		2.41 (2.25-2.58), <0.0001
≥3	27.43		4.41 (3.87-4.43), <0.0001

Patients undergoing thoracoabdominal surgery NSQIP 2005-2012

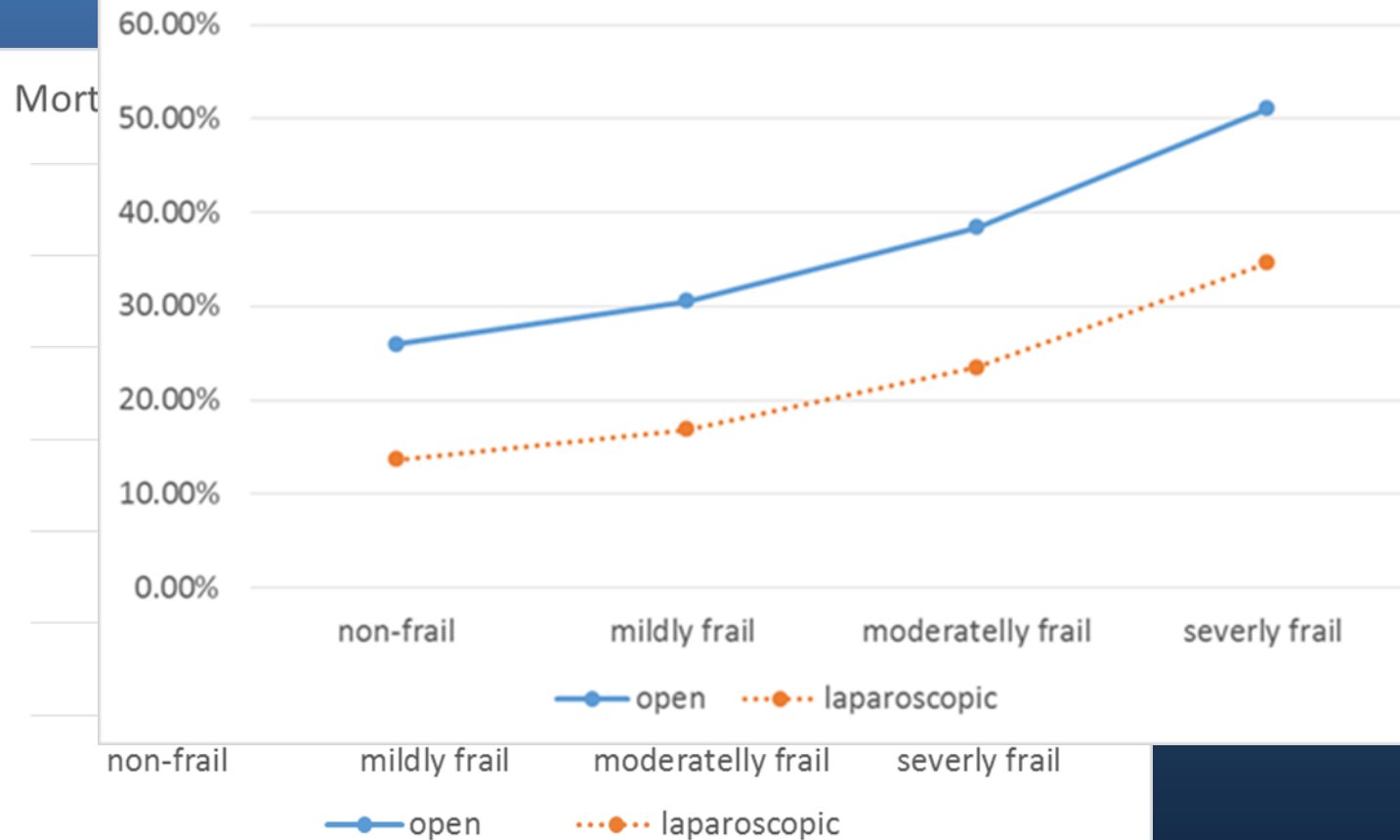
Type of complication by frailty



CONCLUSION

- Frailty is associated with F2R
 - Frail patient are more likely to have morbidity and mortality following major thoracoabdominal surgery
 - This mortality is associated with a decreased ability to rescue patients
- Preoperative identification of frail patient may help guide in patient selection, management and postoperative care

Morbidity of colon resection by procedure and frailty score



Association of Increasing Frailty with Detrimental Outcomes after Pancreatic Resection

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An association between detrimental outcomes and frailty has been documented; however, the impact specific to pancreatic surgery is unknown. Using NSQIP data, patients were classified as non-, mildly, moderately, or severely frail. A total of 16,028 patients were included in the study; most of the patients were white (78.5%) and underwent pancreaticoduodenectomy (PD) (67%). Complications occurred in 17.6 per cent cases, and the median length of stay (LOS) was 11.89 days. Prolonged LOS and mortality occurred in 9.1 and 2.3 per cent of the cases. In the PD group, most of the patients were mildly frail (40.6%), followed by nonfrail (39.83%), whereas in the distal pancreatectomy (DP) group, the majority were nonfrail (43.82%), followed by mildly frail (39.37%) ($P < 0.0001$). The 30-day complications, mortality, and LOS were significantly higher in patients undergoing PD compared with DP (19.5 vs 14.3%, 2.8 vs 1.2%, and 13.4 vs 8.7 days, respectively; $P < 0.0001$). PD conferred a significantly higher risk of death in all frailty groups compared with DP [nonfrail: odds ratio (OR) 1.76, mildly frail OR 1.03, moderately frail OR 2.03, $P < 0.05$], with the exception of severely frail

- Pancreatic surgeries are high-risk interventions with significant morbidity and mortality
- Data from the ACS-NSQIP Participant Use Files

Mortality of Pancreas Resection by Procedure and Frailty Score



Frailty Cost: Economic Impact of Frailty in the Elective Surgical Patient

Justin G Wilkes, MD, Jessica L Evans, MS, B Stephen Prato, MS, Steven A Hess, MD, FACP, FACC, Dougald C MacGillivray, MD, FACS, Timothy L Fitzgerald, MD, FACS

BACKGROUND: Frailty in the surgical patient has been associated with increased morbidity, mortality, and failure to rescue. However, there is little understanding of the economic impact of frailty.

STUDY DESIGN: A prospective database of elective surgery patients at an academic medical center was used to create a modified version of the Risk Analysis Index (RAI), a validated frailty index. This included 10,257 patients undergoing elective operations from 2016 to 2017. Patients were classified as not frail (RAI = 0), somewhat frail (RAI = 1 to 10), or significantly frail (RAI > 10). Cost, revenue, and income data were procured from the finance department. Univariate and multivariate analyses were performed.

RESULTS: Frail patients were more likely to be older (65 years vs 50 years; $p < 0.001$) and inpatient (19% vs 36%; $p < 0.001$). General surgical, gynecologic, urologic, and cardiothoracic services operated on a higher percentage of significantly frail patients compared with orthopaedic, neurosurgical, and vascular ($p < 0.001$). On univariate analysis, frail patients were more likely to die (0% vs 0.4%; $p < 0.001$) and have increased length of stay (0.8 vs 2.1 days; $p < 0.001$), higher total cost (\$6,934 vs \$13,319), and lower net hospital income (\$5,447 vs \$3,129) ($p < 0.001$). On multivariate analysis, frailty was independently associated with increased direct cost (odds ratio [OR] 2.2; $p < 0.001$), indirect cost (OR 1.9; $p < 0.001$), total cost (OR 2.2; $p < 0.001$), and net income (OR 0.8; $p < 0.001$). Stratified by service line and inpatient vs outpatient status, frailty continued to be associated with increased direct cost, indirect cost, total cost, and decreased hospital income.

CONCLUSIONS: Although a significant number of data exist on the impact of frailty in the surgical patient, the economic impacts have only limited description in the literature. Here we demonstrate that frailty, independent of age, has a detrimental financial impact on cost and hospital income in elective surgery. (J Am Coll Surg 2019;■:1–10. © 2019 Published by Elsevier Inc, on behalf of the American College of Surgeons.)



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Studies of cost and frailty in Surgery

- Sarcopenia in Aortic Valve Replacement—Estimate based on CPT code
- Sarcopenia in Thoracolumbar Surgery—Hospital Billing Data
- Sarcopenia in Trauma Patients—Hospital Finance
- Sarcopenia in ACS Patients—Institutional Accounting System
- Frailty Score in TJA Patients—National/Institutional Accounting System
- Frailty Score in Trauma—Estimated cost
- Frailty score from ACS services in Canada—Estimate based on Patient Questionnaire
- Frailty Score in Elective Colorectal Surgery—Estimated costs

Hawkins, R. B., et al (2018). [Ann Thorac Surg 106\(1\): 39-45.](#)

Eamer, G. J., et al (2018). [Can J Surg 61\(1\): 19-27.](#)

Bokshan, S. L., et al (2017). [J Neurosurg Spine 27\(6\): 676-680.](#)

Kaplan, S. J., et al (2017). [JAMA Surg 152\(2\): e164604.](#)

Gani, F., et al (2016). [Surgery 160\(5\): 1162-1171.](#)

McIsaac, D. I., et al (2016). [Bone Joint J 98-B\(6\): 799-805.](#)

Gonzalez, K. W., et al (2015). [J Trauma Acute Care Surg 78\(5\): 970-975.](#)

Robinson, T. N., et al (2011). [Am J Surg 202\(5\): 511-514.](#)

FRAILITY INDEX

Table 10 Frailty Criteria^{89,90}

Shrinking/weight loss
Unintentional weight loss 10 pounds or greater in the last year
Decreased grip strength/weakness
Measured by having the patient squeeze a handheld dynamometer
Adjusted by gender and body mass index
Exhaustion
Measured by responses to questionnaire about effort and motivation
Low activity
Measured by responses to questionnaire about leisure-time activities
Slow walking speed
Measured by speed at which patient could walk 15 feet
Average 3 trials at normal pace
Adjusted for gender and height
Each criterion scored with a 0 or 1. Scores of 2 to 3 define intermediate frail. Scores of 4 to 5 define frail.

Hall, D. E., et al. (2017) JAMA Surg 152(2): 175-182.

Risk Analysis Index

Continued

C. Cognition, Residence & Activity of Daily Living

9. Do you reside in a setting other than independent living?

If yes, check answer: Skilled nursing facility ☐ Assisted living ☐ Nursing home ☐
No= 0 Yes= 8 _____

If yes, were you admitted within the past 3 months? No ☐ Yes ☐

D. Activities of Daily Living & Cognitive Decline (Circle score for each ADL)

10. Mobility/Locomotion	11. Eating	12. Toilet Use	13. Personal Hygiene
0. Independent	0. Independent	0. Independent	0. Independent
1. Supervised	1. Supervised	1. Supervised	1. Supervised
2. Limited assistance	2. Limited assistance	2. Limited assistance	2. Limited assistance
3. Extensive assistance	3. Extensive assistance	3. Extensive assistance	3. Extensive assistance
4. Total Dependence	4. Total Dependence	4. Total Dependence	4. Total Dependence

14. Have your cognitive skills or status deteriorated over the past 3 months? No ☐ Yes ☐ (see score chart)

ADL Score without Cognitive Decline (Sum of ADL Scores)	ADL Score with Cognitive Decline
0	ADL Score -2
1,2	ADL Score -1
3,4	ADL Score 0
5-7	ADL Score +1
8,9	ADL Score +2
10,11	ADL Score +3
12,13	ADL Score +4
14-16	ADL Score +5

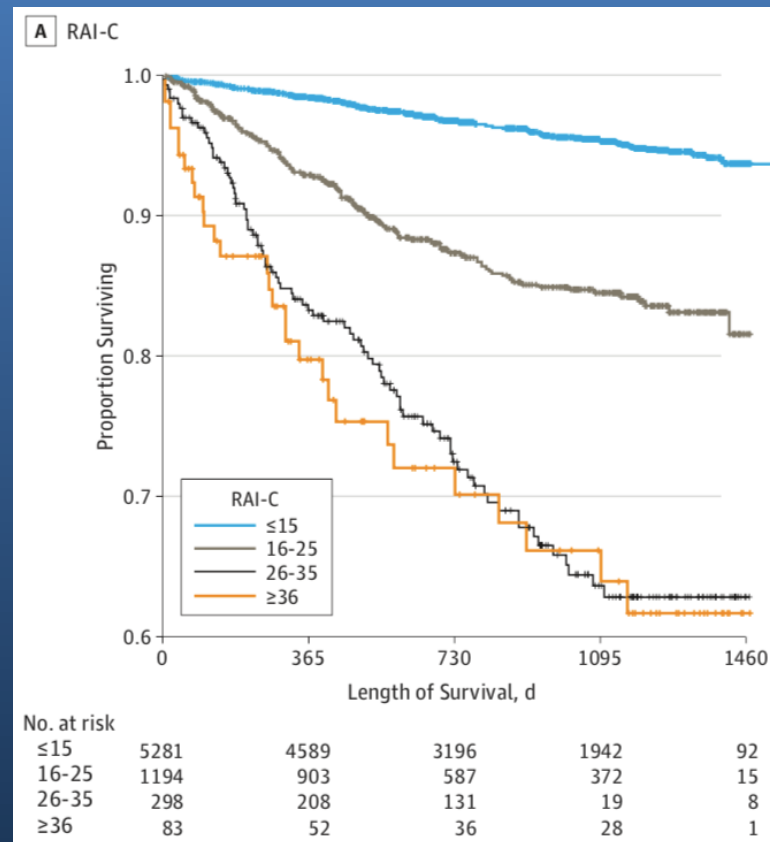
Score without cognitive decline _____ (0 to 16)
or

Score with cognitive decline _____ (-2 to 21)

Total RAI Score: _____

Hall, D. E., et al. (2017) JAMA Surg 152(2): 175-182.

RAI-C Predicts Post-operative Survival



Hall, D. E., et al. (2017) JAMA Surg 152(2): 175-182.

Hypothesis

- **Frailty in the elective surgery patient is associated with:**
 - Increased direct, indirect, and total cost
 - Decreased hospital income

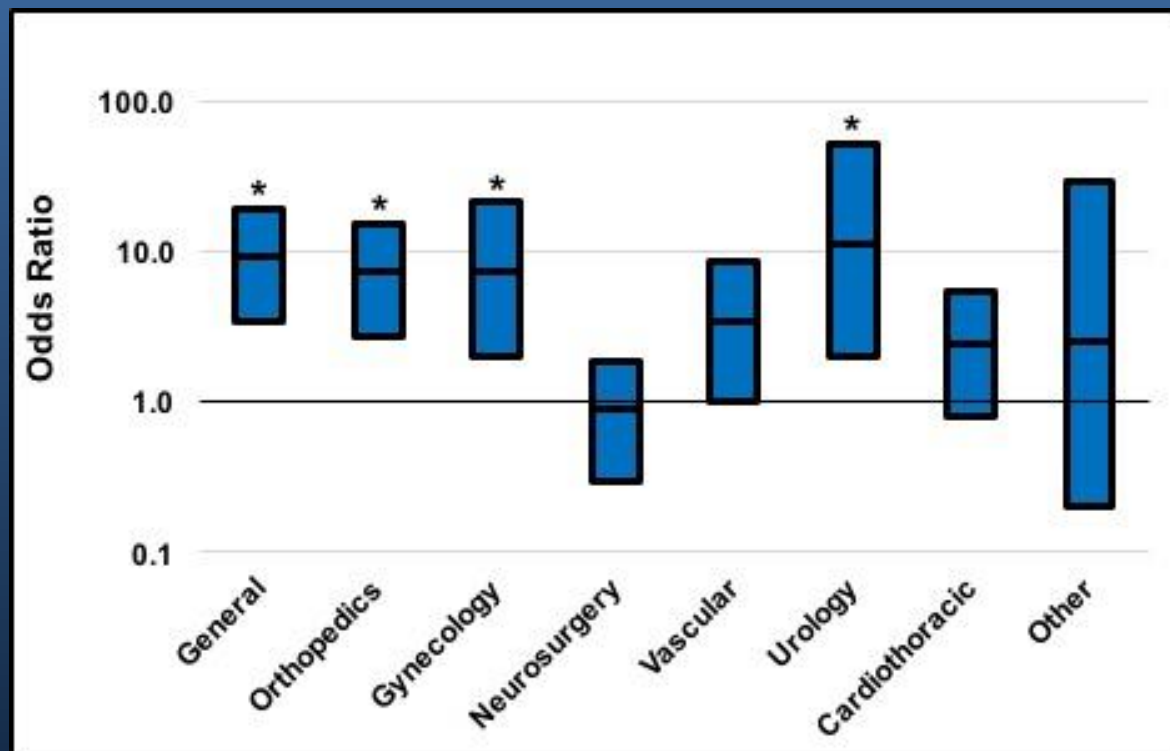
Methods

- Retrospective review of prospectively collected database
- Elective Surgery Patients (all specialties)
 - PREP Questionnaire
 - Re-coding
 - Univariate Analysis
 - Multivariate Analysis

Frailty Independently Associated with Total Cost Independent of Age

Characteristics	<\$5331	>\$5331	p-value	OR	p-value
Age (Mean +/- SD)	55 +/-17	61 +/-15	p < 0.0001	1.0	p = 0.4
Race					
White	50%	50%	p = 0.0002	1.0	p = 0.7
Non-white	60%	40%		0.9	
Gender					
Male	50%	50%	p = 0.7		
Female	50%	50%			
Service					
General Surgery	61%	39%	p < 0.0001	1.0	p < 0.0001
Orthopedics	37%	63%		1.5	
Gynecology	52%	48%		2.1	
Neurosurgery	35%	65%		2.6	
Vascular	36%	64%		2.2	
Urology	61%	39%		0.8	
Cardiothoracic	11%	89%		2.0	
Other	82%	18%		0.5	
Frailty					
0	60%	40%	p < 0.0001	1.0	p < 0.0001
1-10	40%	60%		1.7	
>10	38%	62%		2.2	
Patient type					
Inpatient	2%	98%	p < 0.0001	76	p < 0.0001
Outpatient	68%	32%		1	
Total	5127	5127			

The Effect of Frailty on Net Income is variable by Service line for Inpatient Procedures



Conclusions

- **Frailty is an independent predictor of economic outcomes in elective surgery**
 - Increased Cost
 - Decreased Net Income
- **Multivariate analysis with inclusion of frailty, negates effect of age on these parameters**

TABLE 3. Revised Risk Analysis Index Scoring for the Prospective (RAI-C) and Retrospective (RAI-A) Versions

Variable	Revised RAI-A		Revised RAI-C	
Male Sex	3		3	
Weight Loss	4		4	
Poor Appetite	4		4	
Renal Failure	8		8	
Chronic/Congestive Heart Failure	5		5	
Shortness of Breath	3		3	
Residence other than Ind. Living	1		1	
Age* cancer	w/o cancer	w/cancer	w/o cancer	w/cancer
Age				
≤19	0	28	0	28
20–24	1	29	1	29
25–29	4	29	4	29
30–34	6	30	6	30
35–39	8	30	8	30
40–44	10	31	10	31
45–49	12	31	12	31
50–54	14	32	14	32
55–59	16	32	16	32
60–64	18	33	18	33
65–69	20	34	20	34
70–74	22	34	22	34
75–79	24	35	24	35
80–84	26	35	26	35
85–89	28	36	28	36
90–94	30	36	30	36
95–99	32	37	32	37
100+	34	37	34	37
ADL* cog	w/o cog	w/cog	w/o cog	w/cog
Totally dependent	14	16		
Partially dependent	7	11		
Independent	0	5		
ADL score				
0			0	5
1			1	6
2			2	6
3			3	7
4			4	8
5			4	8
6			5	9
7			6	10
8			7	11
9			8	11
10			9	12
11			10	13
12			11	13
13			11	14
14			12	15
15			13	15
16			14	16
Total RAI (range)	0 to 81		0 to 81	

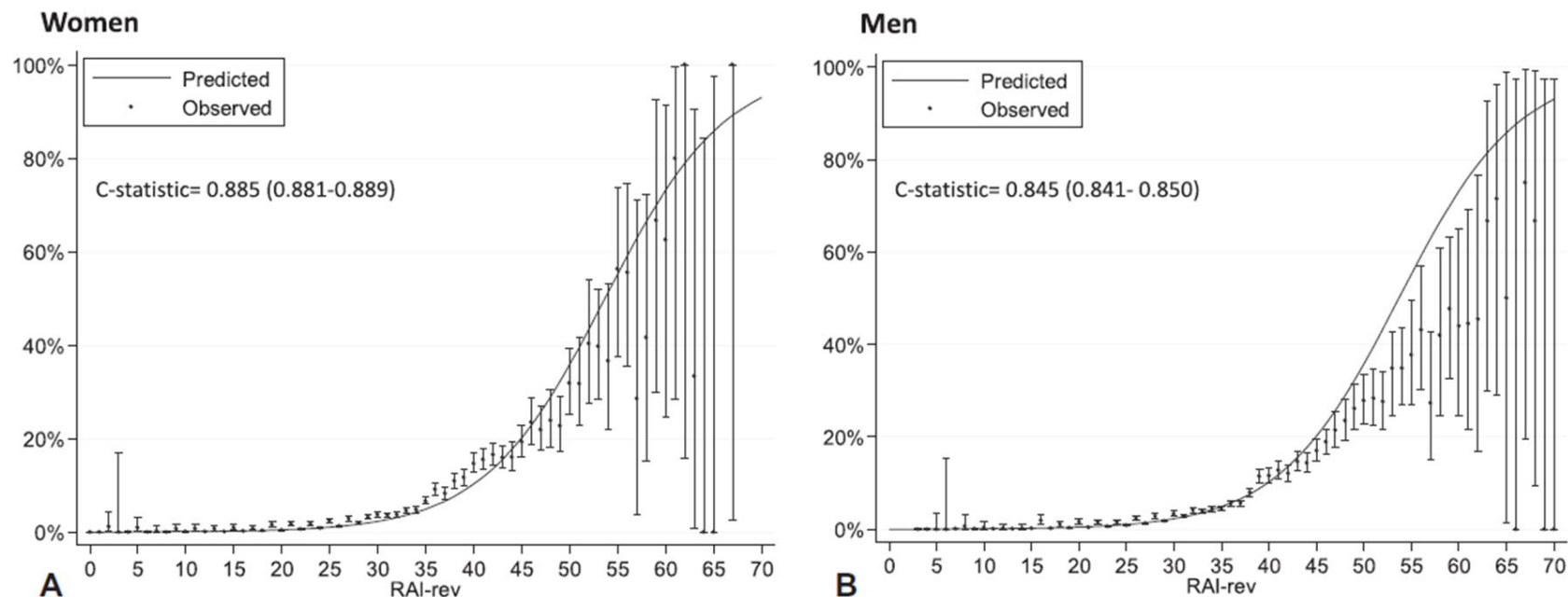
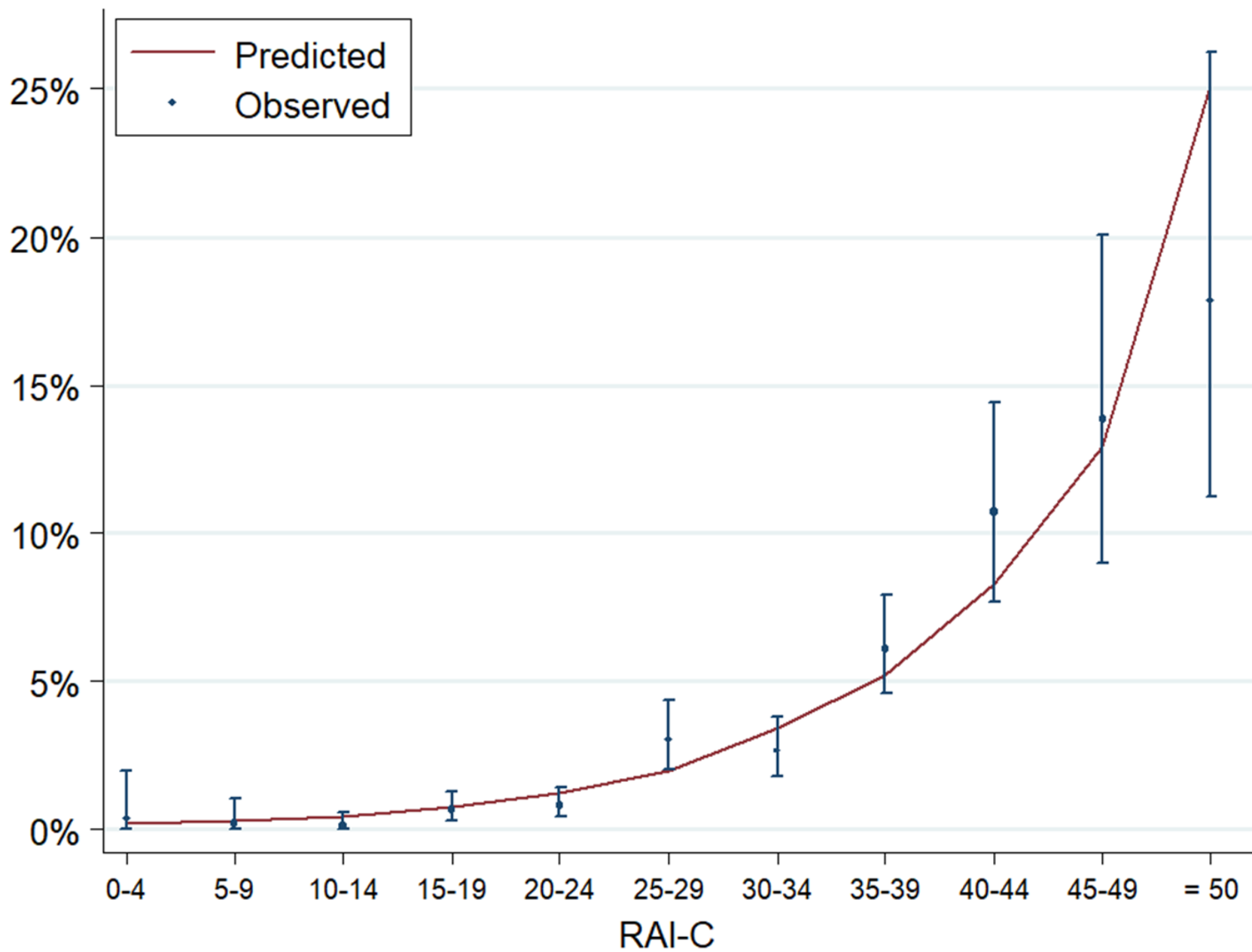
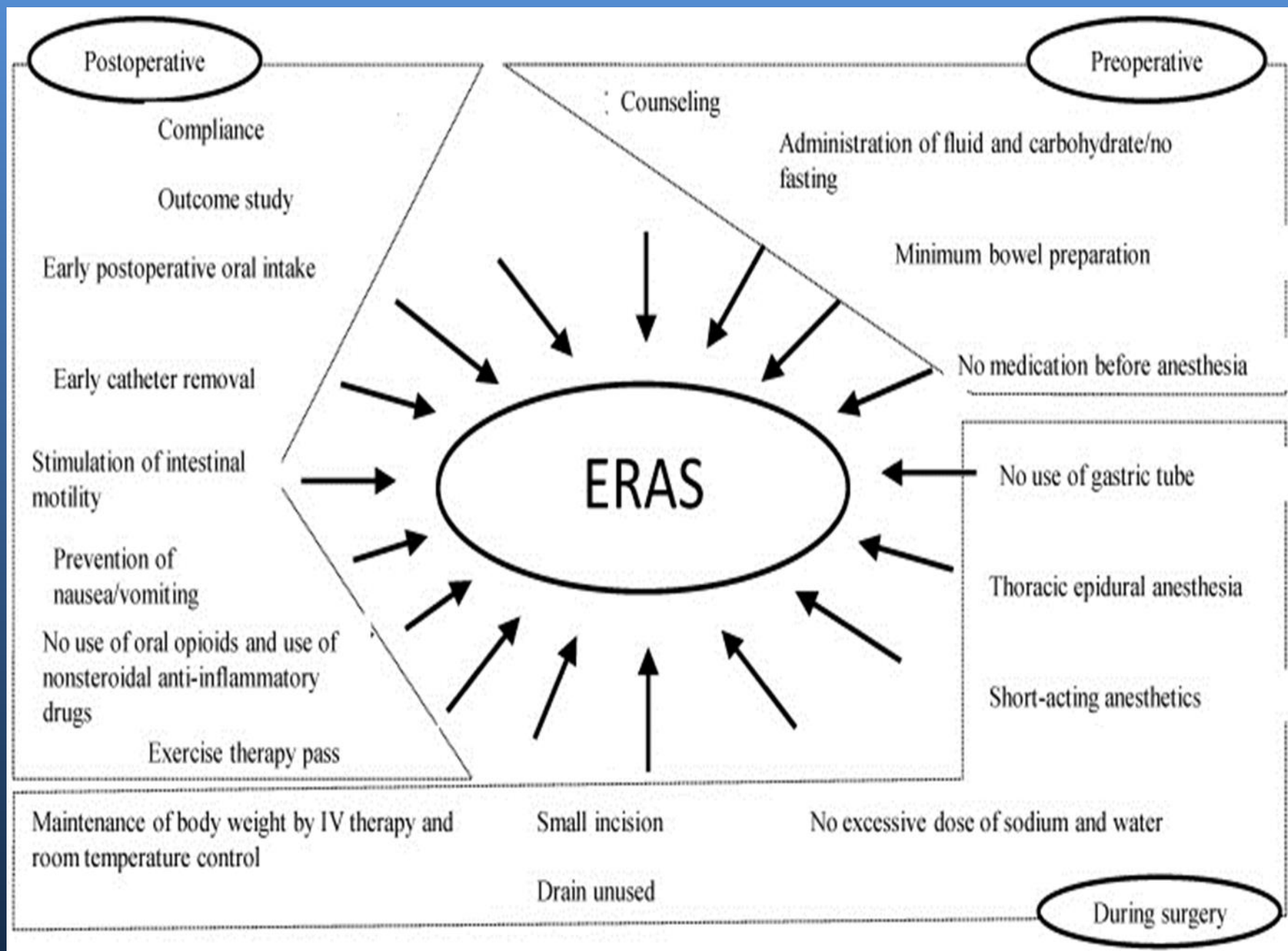


FIGURE 2. Model calibration: observed versus predicted 30-day mortality across the range of RAI-rev scores in (A) women [$c = 0.89$] and (B) men [$c = 0.85$]. Predicted mortality for patients undergoing elective surgery in the American College of Surgeons National Surgical Quality Improvement Program (ACS-NSQIP) database was calculated using logistic regression with RAI-rev scores as the sole independent variable. The predicted mortality for each revised RAI score is plotted against the observed mortality with 95% confidence intervals.

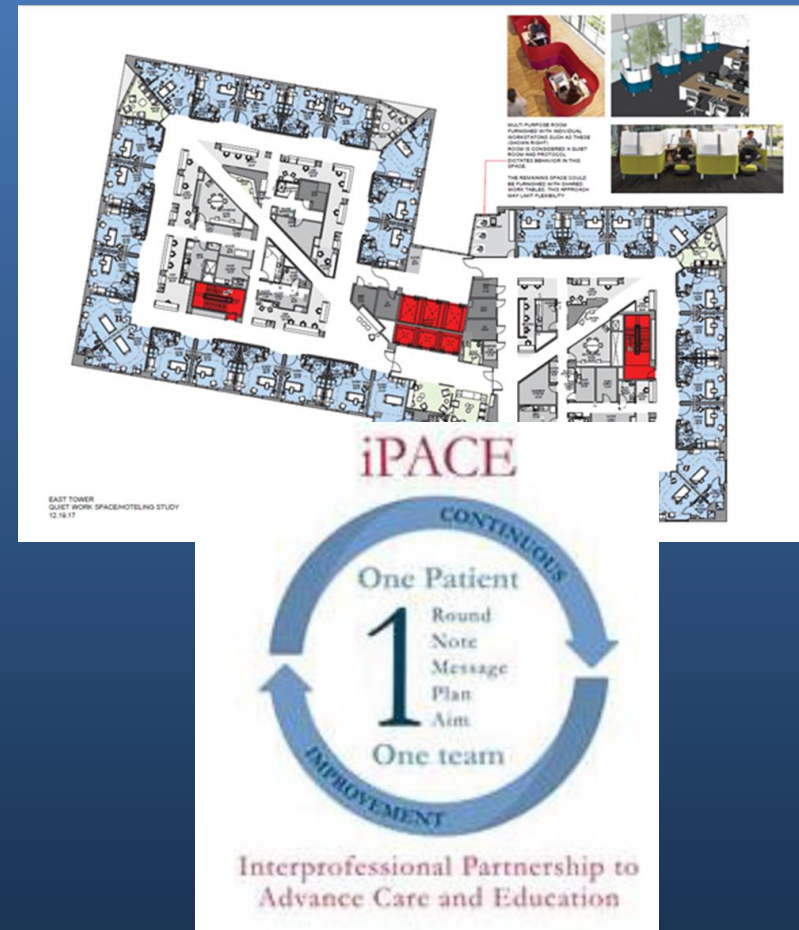
Mortality within 180 Days
after Surgery





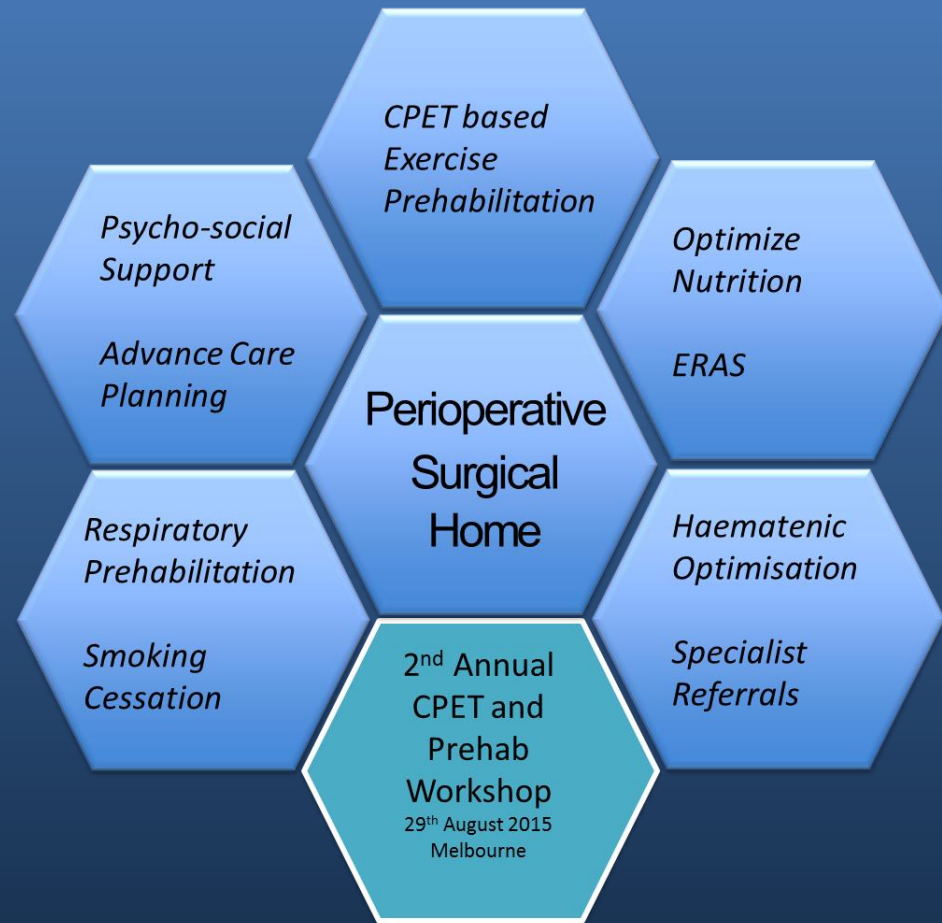
Patient Cohorting and Inter-professional Care

- Patient cohorts
 - E6- Complex GI, Colorectal, Thoracic, Head and Neck, and Urology
 - High-performing teams
- iPace
 - MMC One of only eight US hospitals
 - New Pathway Innovators initiative, focused on improving
 - Improve the quality and safety
 - fully integrating medical education in interprofessional setting



Perioperative Surgical Home

- Coordinate care surgical patient
 - From decision to do surgery to 30 days postoperative
- Evidence based practice
 - Minimize variation



Conclusions

- Frailty is decreased physiologic reserve, greater than expected for age
- Frailty is an important predictor of morbidity, mortality, and cost in the surgical patient
- Frailty is associated with failure-to-rescue after surgery

Conclusions

- Frailty can be measured prospectively
 - These data can be used in patient selection and optimization and post-operative care modification
- Ideally programmatic approach to patient care
 - Perioperative surgical home

