



Contents lists available at ScienceDirect

## European Journal of Surgical Oncology

journal homepage: [www.ejso.com](http://www.ejso.com)

## The opposite of undertreating is frailty screening

Studies demonstrating the undertreatment of solid cancer in senior adults are not new. It has been shown by De Angelis et al. [1] at a European level in 2014 and was demonstrated once again by the United Kingdom (UK) National Cancer Intelligence Network [2]: older patients with cancer have worse oncological outcomes as they receive less surgery when compared to their younger counterparts.

The very interesting manuscript by Birch et al. [3] based on 52,922 patients, of which 11,924 are 80-years or older, should not then come as a shock. Nevertheless, it is upsetting to note that, even in a modern and advanced health care system such as the National Health Service (NHS), rectal cancer patients can receive inconsistent treatment.

These new findings are even more relevant since modern rectal cancer surgery was first described and implemented in the UK by Professor Heald who recognized the essence of surgical cancer care and established the need for Total Mesorectal Excision (TME) [4]. It is interesting to note that several surgeons, even in the homeland of TME, prefer not to follow Professor Heald's teaching for senior adults.

As surgical trainees, we have been taught that deciding when not to operate is more challenging than determining when to operate. As difficult as it is, this choice should be based not on prejudice or shallow analysis (i.e. patients' age), but on solid data. Birch et al. should be congratulated for demonstrating that, by withdrawing surgical care, we may increase that single human being's chances of dying from cancer in the immediate future.

After adjusting for the Charlson Comorbidity Index (CCI) score, stage, sex and the Index of Multiple Deprivation category, older patients still receive less surgical treatment based on age alone as compared to patients <70-years old (66.5% vs. 31.7%). Unfortunately, this translates to a higher chance of cancer-related death at 1 year in patients (within any group) who did not undergo major surgery [3].

Despite the publication of multiple guidelines by several societies involved with cancer care in senior adults [5] over the last decade, a frailty screening assessment is still not widely utilized in clinical practice or reported in the literature. CCI is unfortunately not accurate enough to define a patient's frailty and the cut-off score of 3, reported in the manuscript, is less accurate in correlating with frailty than the previously identified threshold of  $\geq 6$  [6,7]. While many publications have suggested that we have moved beyond using age alone as a surrogate for frailty [8–10], unfortunately, this manuscript has shown that, despite the best of intentions, we have more work to do.

Avoiding the use of frailty screening in clinical practice and in our publications affects not just our patients, but also surgeons and the scientific community.

Firstly, when we omit frailty screening, it is a loss for our patients who may receive inappropriate treatment based on gut feelings and/or age alone instead of taking into account the level of independence, cognition, nutritional and social status, or an accurate morbidity evaluation. The fact that a patient will not receive appropriate patient-centered cancer care based on age alone should not be accepted. Now that the misconception that older patients in general have worse outcomes has been shown to be untrue and, instead, they have equivalent rectal-cancer specific outcomes compared to younger patients, patient frailty and treatment goals should be driving care rather than age [11]. In fact, elderly patients were shown to have equivalent quality of life scores, better Social Difficulty Inventory scores and improved ability to cope with invasive surgical procedures compared to younger patients [3].

Secondly, failure to properly define frailty and stratify patients makes it more difficult for surgeons to care for elderly patients. If the case mix is not properly reported, poor outcomes may weigh heavily on the surgeon and may result in administrative consequences. This makes it more difficult to find surgeons to care for this ever-increasing population of patients.

Finally, when we accept, once again, to read and discuss an interesting manuscript where no sound conclusions can be drawn without frailty data, we lose as a scientific community. We are unable to conclude what the data means to our patients without the information on frailty to decide if the patients were undertreated, properly treated, or overtreated.

Numerous, inexpensive and simple questionnaires and tests can be used in our clinical, day-to-day, busy surgical practice to stratify older patients' risk [12,13]. For example, the Flemish version of the Triage Risk Screening Tool is a five-item assessment that can easily be asked of the patient or their caregiver, even in urgent/emergent scenarios [7]. Alternatively, a composite of the G8, history of falls, Timed up and Go, and the mini-Cog can signal patients who need Comprehensive Geriatric Assessment and pre-treatment discussion and optimization [11].

We note that Dr. Birch's investigation is retrospective and frailty assessment was not the standard of care when treating older cancer patients over the study period. We appreciate this study bringing to light the need for reporting data on frailty going forward. In the future, there will be no excuse, in the NHS or in any modern healthcare system, for not implementing and reporting on frailty assessment; not doing so will constrain us to suboptimal, inappropriate and harmful cancer treatment. The opposite of

DOI of original article: <https://doi.org/10.1016/j.ejso.2019.01.005>.

<https://doi.org/10.1016/j.ejso.2019.01.180>

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undertreating (or overtreating) is not the 'standard of care', it is screening for frailty.

### Conflict of interest statement

Dr Saur has nothing to disclose.

Dr Montroni has nothing to disclose.

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Available online 29 January 2019