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Editorial

Multidisciplinary Unit for the Surgical Management of Geriatric Patient☆

Unidades funcionales para el manejo quirúrgico del paciente geriátrico

It is evident that the life expectancy is growing in the Western world. However, some age-related diseases are likewise becoming more prevalent. In our specialty, this reality is observed in the increase of new cases of certain diseases, such as colorectal cancer, benign biliary disease, functional gastrointestinal disorders and abdominal wall disease in this population group. What all these diseases have in common is that one of the most important factors for their development is simply longevity.[1] The number of scientific articles published about the surgical treatment of octogenarian patients with colorectal cancer has significantly increased in recent years.[2,3] In this issue of our journal, García Cabrera et al.[4] have published an article that shows us a problem that occurs in advanced age and greatly impacts the quality of life of affected patients: fecal incontinence. Despite age, general physical fitness is considered the most relevant factor for clinical decision making in the geriatric population. Therefore, along with improvements in the perioperative treatment of elderly patients, improvements have also been made in the treatment of frail patients or those with decreased physiological reserve in multiple organ systems. Consequently, for the management of any surgical disease in geriatric patients, some special considerations must be kept in mind, which justifies the creation of specific programs or functional units aimed at the management of these patients.

In 2010, a survey was conducted in the majority of hospitals in the United Kingdom, which showed that only one-third had medical support services for elderly or frail surgical patients. Furthermore, those that existed tended to provide reactive care in the postoperative period after the appearance of medical problems rather than proactive measures throughout the treatment process. This finding was later confirmed by the first report of the National Emergency Laparotomy Audit (NELA).[5] For these reasons, the *Proactive care of older people undergoing surgery* (POPS) program[6] was initiated with the following objectives: (a) to improve the understanding of the problems related with perioperative care for elderly or frail patients undergoing elective or emergency surgery; (b) to provide a forum for education and training in geriatric perioperative medicine for doctors and healthcare professionals; (c) to facilitate the nation-wide dissemination of effective treatment models and to work toward the standardization of clinical care for elderly surgical patients; (d) to facilitate collaboration among all interested parties involved in the care of these surgical patients (through the specialties of geriatrics, anesthesiology, surgical specialties, etc.); and, finally (e) to promote collaborative research among units, disciplines and specialties in order to improve results for older surgical patients.

In the USA, the American College of Surgeons has promoted the *Coalition for Quality in Geriatric Surgery Project*.[7] In collaboration with more than 50 interested organizations, this Project's purpose is to establish standards, develop relevant measures or actions, educate healthcare providers and patients and, in a very relevant manner, raise awareness about the surgical needs of the geriatric population in all hospitals of the country through this program. This initiative, which is scheduled to launch in 2019, will use the 4 principles for continuous quality improvement: establish standards, define the appropriate infrastructure, collect rigorous data and subsequently verify the results of the actions implemented. Undoubtedly, the program is expected to improve not only geriatric perioperative care but also the entire cycle of the surgical process (from diagnosis to postoperative follow-up).

In our country, it seems that we have not yet developed similar initiatives, except for the successful model implemented in trauma services where need has been key in the creation of the so-called orthogeriatric units.[8] Our Service was a pioneer in our country and created a functional geriatric surgery unit in 2010. With this multidisciplinary management,

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we observed that not only was survival comparable to published standards, but also the quality of life in patients older than 80 years with surgically treated colorectal cancer was comparable to a control group of younger patients.[9]

These programs are primarily focused on detecting which patients will require this special attention, evaluating not only the age but also *physiological reserve* or *functional status* and degree of patient autonomy. For this purpose, different clinical assessment scales are used in addition to the already classic comorbidity scales, such as the ASA or the Charlson index. The Karnofsky[10] and Barthel[11] scales, or more recently the Edmonton Frail Scale,[12] for example, have become very useful tools in the detection of these patients. Subsequently, a multidisciplinary group of professionals meets to discuss the most complex cases and to design the best clinical approach, including diagnostic tests, surgery/perioperative care, medical and social support upon patient discharge, and the most appropriate follow-up in Primary Care. In short, steps are taken to adapt the aggression of surgical management or treatment to the patient's response capacity. In this issue of our Journal, the authors Castellví Valls et al.[13] present their relevant experience in the management of frail patients with colorectal cancer, and the utility of applying a special program to optimize the perioperative care of these patients. With this change in care, the group demonstrates an improvement not only in clinical results, but they also provide original economic data to prove that there is also a better use of the economic resources directed to the treatment of these patients. Given this context, now may be an opportune moment to be proactive and create multidisciplinary groups in all our hospitals dedicated to the care of these patients requiring surgery to extend life and, especially, to improve the quality of it.

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