Rev Esp Geriatr Gerontol. 2014;49(2):47–48

Revista Española de Geriatría y Gerontología

www.elsevier.es/regg

EDITORIAL

# Comprehensive geriatric assessment in the XXI century

## Valoración geriátrica integral siglo XXI

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Since 1984,[1,2] when the first randomized clinical trial (RCT) of comprehensive geriatric assessment (CGA) was published from the geriatric unit at the Sepulveda VA Medical Center, there have been more than 50 RCTs of CGA and several meta-analyses summarizing the trial results.[3,4] The overwhelming consensus confirms the clear effectiveness of CGA in both hospital and non-hospital settings. As geriatric medicine has grown and increased its presence across the care spectrum—from hospital to outpatient to home care to nursing home—CGA has been central to the care process used in all these levels of health care.

This expansion of CGA-based geriatric medicine programs has occurred in the context of a usual care system that has consistently exhibited a high prevalence of under-diagnosis and suboptimal treatment of older persons. Moreover, medical advances that have allowed the compression of morbidity problems in the last years of life have resulted in a parallel increase in the prevalence of frail and pre-frail geriatric patients. And these processes have become even more pronounced as the elderly population as a whole has expanded.

In the 21st century, geriatric medicine should build upon the advances of the last decades of the 20th century by solidifying universal screening approaches to healthy and pre-frail elders and standardizing the frequency of these assessments. Frail geriatric patients, who were previously diagnosed or who were detected through screenings, will continue to require a periodic structured CGA and will remain the primary recipients of CGA. Additionally, different profiles of frail elderly patients should receive thorough assessments of specific abnormalities identified in the initial core CGA. Using combined indicators of frailty and specific identified pathologies will allow a risk stratification that facilitates individualized medical decisions.[5]

This branching, multi-level approach to CGA can be of great benefit when applied systematically in daily practice. It begins with screening of all older adults for evidence of frailty or increased risk. This screening can be done during a primary care visit or via a screening questionnaire, sent by post or email, to be filled in at home by patient or primary caregiver. If the screen identifies the person as frail or pre-frail, this person would be referred for CGA.[6] This CGA consists of a complete geriatrics history and physical examination with inclusion of geriatric assessment scales that facilitate accurate clinical, functional, psychological and social examination. On the horizon in this century, we will likely see CGA evolve and improve with addition of supplementary new technology, such as gene and biological markers tests.[7] For example, a recent paper compares the accuracy of CGA alone in diagnosing frailty to CGA with the addition of observing increases in IL6 and C-reactive protein levels.[8]

CGA is geriatric medicine's primary diagnostic tool and is a distinctive technique. As a recent paper published in *The Lancet* reminds us, development of different profiles of frailty that can be identified through CGA permits more accurate prediction of adverse health outcomes. Nevertheless, our great challenge remains the efficient detection of frailty in our patients, devising optimal treatment approaches, and documenting the effectiveness of our efforts.[9] We do not perform our activity as an isolated strategy. Our specialty drinks at integrated interdisciplinary team fountains. We need to perpetuate CGA care planning as efficiently as possible in conjunction with multiple other disciplines. We must emphasize our importance as case managers in contact with other specialties and work more closely with primary care, within which the vast majority of our patients reside.[10] Our enemies are not other specialties or disciplines. Our only enemy is our own not living up to the high standards of geriatric care that we know we are capable of.

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0211-139X/$ – see front matter 
http://dx.doi.org/10.1016/j.regg.2013.08.003

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