

LETTER TO THE EDITOR

[Translated article] Orthogeriatrics. Are we walking the right direction?



Ortogeriatría. ¿Caminamos en la dirección adecuada?

We would like to congratulate Dr. Gamboa-Arango et al. and extensively the Geriatric Department of the Hospital de Igualada for their study on the prognostic factors of good functionality at 12 months in patients with hip fracture (HF).¹ Their work over many years in the field of orthogeriatrics at Igualada Hospital is very interesting. From the outset the objectives of HF treatment have been to preserve life and maintain function. The collaboration between geriatric and orthopaedic and trauma services has been a pioneering example of medical-surgical collaboration.² The geriatric department has contributed comprehensive geriatric assessment (CGA) and analysis of the data it provides. However, we must now move forward by integrating information on patient preferences and the study of patients' physiological reserve into this analysis.

When making decisions following a HF, we are confronted with the vision of a society that demands that patients remain functionally unimpaired and independent in the basic activities of daily living (ADLs) for as long as possible.³ However, ageing is associated with progressive deterioration of physiological reserve which in some cases may make it difficult for patients to recover their baseline situation after HF. We know that after HF only about 30% can fully recover.⁴ Tools are important that can objectively guide patients and families on the care needs that the patient will require. In our view, being able to inform clearly and objectively when it is time to care and not to rehabilitate remains a very difficult task. Analysis of health-related quality of life (HRQoL) and the use of frailty indices can aid clinical and resource management decisions.

Despite high mortality after HF, 70% of patients are still alive at one year.⁵ Research models in the field of orthogeriatrics have focused on clinical aspects of mortality, medical and surgical complications, and functional recovery. However, we are increasingly aware that patient recovery after HF needs to be analysed as a multidimensional concept. To that end, we use questionnaires measuring HRQoL or PROMs

(Patient Reported Outcomes Measures) which allow patients to subjectively assess different dimensions of health (physical, psychological, and social) that are important for their well-being. Of all the HRQoL measurement instruments, the EuroQoL-5D (EQ-5D) is the most widely used and recommended in patients with HF,^{5,6} and we should routinely include it in our studies.

The study of frailty and the tools and protocols to identify it in clinical practice will help us individualise our patients' clinical prognosis and functional recovery, care planning and therapeutic intensity.⁷ However, the evidence from frailty studies has not yet been generally or consensually applied in clinical practice²; therefore, we find the work of Dr. Amblás et al. with the Frail-VIG index⁸ very interesting. Applying it to orthogeriatrics would allow us to stratify patients according to degree of frailty, determining the level of therapeutic intensity based on a goal of survival, functionality or well-being, or symptom control.

The geriatric population is characterised as being very heterogeneous⁹ and, depending on their functional and cognitive reserve levels and comorbidities, patients can be classified as fit or well, vulnerable or severely frail.¹⁰ We know that the HF population, compared to their peers without fracture, is a population with more high risk and maximally complex chronic disease.¹¹ The authors' idea in this letter is to consider different tools to help us make person-centred decisions and to identify frailty as a complement to the comprehensive geriatric assessment that elderly patients undergo when admitted with HF. It is not our intention to raise a debate on the criteria for resource allocation, but to obtain more information to help us make decisions and offer the best treatments according to the patient's characteristics, following the principles of utility, proportionality, and equity.

After a year in which the pandemic has conditioned everything, we hope that we will gradually be able to return to some degree of normality as soon as possible to continue making improvements in the different aspects of care for elderly patients with HF.

Level of evidence

Level of evidence v.

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M. de Miguel Artal^{a,*}, O. Roca Chacón^a,
M. Serrano Godoy^a, J. Mas Atance^b

^a *Servicio de Geriatria, Hospital Universitari Santa Maria-Gestió de Serveis Sanitaris, Lleida, Spain*

^b *Servicio de Cirugía Ortopédica y Traumatología, Hospital Universitari Arnau de Vilanova, Lleida, Spain*

* Corresponding author.

E-mail address: mdmartal@gmail.com (M. de Miguel Artal).