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Reply: Outcomes in older patients requiring comprehensive allied health care prior to discharge from the emergency department

Pol, Robert; van Leeuwen, Barbara

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LETTERS TO THE EDITOR

Outcomes in older patients requiring comprehensive allied health care prior to discharge from the emergency department: Reply

Dear Editor,

We have read with great interest the report by Arendts *et al.* describing an extensive risk assessment for older patients presenting at the ED.¹ Their study shows that older patients requiring facilitated discharge can be identified well in advance and safely discharged with an increased likelihood of hospitalisation in the following year. The older population is increasing at an unprecedented rate. This increase in older patients requiring appropriate healthcare requires more insight into possibilities and limitations one may encounter in treating this population.

There is extensive experience in treating fragile older patients at our University Medical Center,^{2–4} and we encourage any research that is carried out within this patient group.

However, although on most parts we agree with the authors' findings and conclusions, a number of important issues remain in our view insufficiently explained.

Not age but vulnerability or frailty is the main determinant of treatment outcome. Although the screening tool used in the present paper leads in that direction, it provides only a brief impression of the actual vulnerability of the patient. It would have been preferable if a validated frailty score, such as PRISMA-7 or Groningen Frailty Indicator (GFI) had been used.^{2,5} Both tests are as easy to use and have a high accuracy. Most likely this would have strengthened the results and led to a better comparability. Similarly, an overview and comparison of the medical history, including medication use, of the included patients is missing. A large study among older (trauma) patients showed that a high comorbidity–polypharmacy score was a predictor of morbidity, mortality, hospital resource utilisation and post-discharge disposition in this patient group.⁶ A recent Cochrane review even concluded that medication review reduces ED contacts, further confirming this important relationship.⁷ Finally, the study population seems limited to patients with minor trauma and ischaemic cardiac disease. Patients requiring vascular surgery, abdominal surgery or pulmonary care seem to have been excluded from the analysis. This not only

leads to a huge selection bias but is also no real representation of the actual caseload. The aforementioned patients exhibit a high recurrence rate when it comes to ED visits and hospitalisation.

In conclusion, although we would like to complement the authors on this very interesting study, the results seem not easily applicable. When treating older patients it is very important to realise that it is not age but frailty that determines outcome.

Competing interests

None declared.

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Robert A Pol and Barbara L van Leeuwen
Department of Surgery,
University Medical Center Groningen,
Groningen, The Netherlands

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