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Letter to Editor

Need for modified PAC form in geriatric age group

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Aging involves a progressive loss of functional reserve to a variable extent in almost all bodily systems. Geriatric patients pose a significant workload to operating theatres and the surgical or intensive care units and the entire health care system. These patients' perioperative care is also becoming complex with an increasing dearth of patients with multiple comorbidities. While compensation for age-related changes is usually sufficient for daily activities, a decrease in physiological reserve is noticeable during times of stress, such as the perioperative period. Anaesthesia risk is more closely associated to the existence of co-existing disorders and the patient's growing age.

Frailty is linked with a range of ageing problems, such as functional decline, mobility impairment, polypharmacy, confusion, dementia, pressure ulcers, slips, malnutrition, and incontinence, all of which hamper postoperative recovery.¹ As a result, it is critical to ascertain a patient's physical, mental, and cognitive health and to assess his or her physiologic reserve during the pre-anaesthetic examination.

Comprehensive preoperative geriatric examinations, which include frailty, diet, mobility aid use, physical activity, cognitive testing, and assessment of mood state, aid in the prediction of perioperative outcomes in elderly patients. In older patients, the risk of postoperative complications, lengthy hospital stays, and delayed or

reduced functional recovery is increased. Numerous tools are available but are not commonly utilised, including the Mini Mental State Examination, the mini-cog test, the elderly mobility scale, and the Charles comorbidity index.

The Mini-Mental State Assessment (MMSE) is a 30-point assessment that is frequently used in research and clinical settings to evaluate cognitive dysfunction.² It helps to estimate the degree and growth of mental disorders and monitor the cognitive changes in people over time, making it a meaningful way to document the person's response to treatment.

The Elderly Mobility Scale (EMS)³ is a valuable and validated instrument for assessing vulnerable elderly adults' roles. This assessment method provides a standardized means for measuring mobility in elderly patients. EMS can be used for tracking status before and after any physical therapy to preserve or achieve independence from activities of daily living.

We propose a modified pre-anaesthetic form for assessment of geriatric patients that includes various tools for evaluation of age-related issues such as functional decline, Frailty, mobility, mental status and comorbidities. Even though commonly used predictive techniques such as age, American Society of Anaesthesiologists (ASA) physical status, Revised Lee's Cardiac Risk Index, Charlson Comorbidity Index, and exercise tolerance as evaluation done only with metabolic equivalent task score (METs) can anticipate biological specific complications,

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but they do not take frailty and elderly syndromes into consideration.⁴Incorporating them in routine PAC can improve patient assessment by giving a fair idea about severity of problems and help in stratifying the level of impairment. Many anaesthesiologists are aware about these tools, but their use is infrequent. We analysed various PAC forms available in various hospitals and searched online but could not find a dedicated predefined format for addressing various relevant issues during geriatric assessment.

A comprehensive preoperative geriatric evaluation of patients must be extended beyond an organ-based or disease-based evaluation. There is an urgent need to raise awareness of this dereliction and to develop a geriatric-specific version of the PAC form. By incorporating these basic outpatient assessments into PACs, we can enhance patient outcomes, minimise anaesthetic and surgical problems, minimize hospital stays, and lower the risk of post-operative cognition impairment.

Conflict of Interest

None.

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