In an era of increased awareness of the limitations of treating surgical patients on the basis of age and the need for objective frailty assessment and optimization, the study from Shahrokni et al\(^1\) presents a key ingredient. They found that in a large self-selected cohort of patients undergoing geriatric comanagement, the mortality rate decreased by more than half despite the same complication rates between groups.\(^1\) Why did the patients in the comanagement group fare better despite similar rates of surgical complications? Although the answer is likely multifaceted, a simple truth is that geriatricians are looking for specific disease processes and complications that are in the blind spot of many surgeons. Early identification and mitigation of these complications may result in improved outcomes. As surgeons, the focus is often on postoperative clinical and oncologic outcomes, but it should be noted that these outcomes are affected by the multidisciplinary, multiphase interventions started preoperatively: this is geriatric comanagement.

Physicians have been historically poor at estimating life expectancy. Therefore, it is easy to see why age was used to determine treatment plans for older patients, often inappropriately.\(^2\) An average 75-year-old person has an 11-year longer life expectancy than a 75-year-old person with multiple comorbidities (17 vs 6 years).\(^3\) How does one determine where an individual patient is located on this continuum? The discussion about and measurement of frailty has become heavily studied and reported on. There are no fewer than 30 screening tests and scoring tools with various interpretations available in the literature, which has made it difficult for nongeriatricians to navigate the world of frailty screening. In a simple way, one can think of frailty as the likelihood that the patient will not meaningfully recover from the planned intervention. However, even in this simplistic view, questions remain around what improvement in frailty is required to undergo surgery, what level of fitness is considered fit enough, and what a meaningful recovery means for the individual patient. The Geriatric Oncology Surgical Assessment and Functional rEcovery after Surgery (GOSAFE) study\(^4\) is a prospective study using 9 previously validated screening tools with the goal of evaluating functional recovery and quality of life after surgery. The final GOSAFE results are expected to identify a composite frailty score that corresponds to postoperative outcomes for the first time. In the meantime, the complexity of interpreting frailty screening results and the optimal means of intervention underscores the importance of including a geriatrician in the multidisciplinary team from the start of treatment, especially for patients with multiple comorbidities or signs of vulnerability.

Despite the ever-growing body of literature highlighting the assessment of frailty and optimization in the perioperative period, there is little consensus about the best way to do it. A recent randomized trial from Carli et al\(^5\) showed that even in the textbook example of a prehabilitation model, prehabilitation alone was not superior to rehabilitation for geriatric patients undergoing colorectal cancer surgery. They evaluated a composite outcome of complications as well as postoperative surgical and functional outcomes. This information had many surgeons questioning whether we are wasting our time with prehabilitation. However, this study highlights the findings from Shahrokni et al\(^1\) well. The optimal recipe for caring for older patients undergoing surgery is not going to include only 1 ingredient. No amount of prehabilitation will compensate for poor surgical technique. On the other hand, if a patient is able to get through surgery without a surgical or geriatric-related complication, they could have potentially done as well without prehabilitation. The obvious problem is that we do not have a crystal ball to determine who is fit enough to undergo...
surgery without complications related to their surgery or their comorbidities. Therefore, a multidisciplinary, multiphase approach is necessary for all patients.

It should be noted how rare randomized trials are in the geriatric surgery literature. We have been taught over and over that level 1 evidence is the highest standard. However, we know that older patients are frequently excluded from randomized trials on the basis of their age alone. We also know that observational, real-world trials, such as the GOSAFE study and the study by Shahrokni et al offer important information that may be missed in the strict nature of a randomized trial. Observational studies of this heterogenous population provide important information and do service to the patients for the sake of improving care and not just satisfying scientific rigor.

A care pathway for geriatric patients should include universal frailty screening. At a pre-chosen frailty screening threshold based on the patient population and resources at the institution, multidisciplinary optimization and prehabilitation should be undertaken. For patients with cancer, in addition to preoperative optimization with a geriatrician, a geriatrician should be present at the multidisciplinary tumor board and present for goals of care discussions. When possible, geriatric patients should be treated with minimally invasive surgery, as in the study by Carli et al, where almost 80% of patients had surgery via a minimally invasive approach. Enhanced recovery protocols are important in geriatric patients and should be modified as needed (ie, more liberal fluid resuscitation in patients with underlying kidney disease or awareness of medication interactions). Finally, geriatric comanagement should be undertaken in the hospital setting and, when needed, postoperatively. If we fail to adopt this multiphase, multidisciplinary pathway, we will continue to see suboptimal study outcomes and suboptimal patient outcomes. The study by Shahrokni et al suggests that a simple intervention of including a geriatrician in the care team may dramatically improve outcomes. There is no doubt that this is a key ingredient in the care of geriatric patients. However, we must continue to strive to find the optimal recipe in a multiphase program or we will continue to fall short in the care of these complex patients.

ARTICLE INFORMATION
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