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Letter to the Editor

Letter to the Editor: comment on "Frailty scoring systems in clinical practice: are we underdiagnosing?"

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Dear Editor,

Frailty has emerged as one of the most critical geriatric syndromes influencing morbidity, hospitalization rates, treatment tolerance, and overall survival and has emerged as one of the most critical determinants of adverse outcomes in older adults, yet it remains inconsistently identified in daily medical practice.[1] Although populations are aging globally, the detection of frailty has not kept pace with clinical need. Frailty is no longer viewed as a vague geriatric concept but rather as a measurable, prognostically significant syndrome characterized by diminished physiological reserves and reduced resilience to stressors.[2]

Despite the availability of frailty assessment tools for nearly two decades, screening remains sporadic, and underdiagnosis persists in outpatient clinics, emergency departments, and inpatient settings.[3] This disconnect between knowledge and practice has implications for mortality, hospitalization duration, functional decline, and healthcare utilization.

Multiple validated instruments, such as the fried frailty phenotype, Clinical Frailty Scale (CFS), Edmonton Frail Scale, and FRAIL questionnaire, have been proposed; yet, integration into internal medicine workflows is far from standardized.[4] Each tool offers different levels of feasibility, sensitivity, and clinical applicability. Although these tools are validated and relatively simple to administer, they are not consistently integrated into internal medicine, cardiology, oncology, nephrology, or primary care settings. Most clinicians acknowledge frailty as a concept but do not routinely document it or formally measure it before making diagnostic or therapeutic decisions. One of the biggest obstacles to early frailty detection is still the gap between awareness and action.

Frailty is frequently overlooked due to time constraints, insufficient training, and an overemphasis on chronological age rather than biological vulnerability. In many institutions, frailty scoring is seen as optional rather than essential. As a result, patients with subtle functional decline or low physiological reserve are often categorized as "fit" or "stable" based solely on basic laboratory tests, vital signs, or self-reported independence. Without formal scoring, these individuals undergo invasive procedures, polypharmacy, or aggressive treatments without adequate risk adjustment. The absence of systematic screening prevents proactive interventions such as nutritional support, physiotherapy, medication review, or shared decision-making based on functional status.[5]

Failure to identify frailty promptly has direct consequences on patient outcomes. Hospitalizations become longer, complication rates rise, and recovery after acute illness or surgery is often delayed. Inappropriate medication regimens, increased risk of delirium, and higher rates of institutionalization are frequently observed in frail individuals who were never assessed formally.[6] Moreover, when frailty is not documented, multidisciplinary interventions are either postponed or never initiated. Treatment goals may not align with the patient's physiological capacity, leading to emotional distress for both patients and families. Ultimately, the health system absorbs higher costs due to preventable adverse events and prolonged care needs.

Given these preventable risks and the systemic burden they create, a structured approach becomes indispensable. Frailty scoring should not be viewed as an additional administrative step but as a clinical necessity. Integrating these tools into admission protocols, outpatient evaluations, and preoperative assessments can transform care planning. When clinicians routinely incorporate frailty scores, they are better equipped to individualize therapies, adjust drug dosages, and determine realistic rehabilitation targets. Hospitals and academic centers that embed frailty assessments into electronic health records and clinical algorithms report improved outcomes and more efficient resource allocation. Making frailty screening part of standard internal medicine practice would increase awareness, guide multidisciplinary collaboration, and improve continuity of care.

Frailty is not merely a geriatric concept but a cross-disciplinary determinant of prognosis and treatment tolerance. Underdiagnosis persists because scoring systems are not routinely applied, despite being practical and valid. To close this gap, healthcare providers must adopt a proactive approach by incorporating frailty assessment into everyday clinical workflows. Education, institutional protocols, and simple screening steps can significantly improve recognition

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rates. By normalizing frailty scoring in internal medicine and related specialties, we can better align treatments with physiological reserve, reduce complications, and improve the quality of life for older adults.

Sincerely,

ETHICAL DECLARATIONS

Referee Evaluation Process

Externally peer-reviewed.

Conflict of Interest Statement

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Author Contributions

All of the authors declare that they have all participated in the design, execution, and analysis of the paper, and that they have approved the final version.

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