Letter to the Editor

Comprehensive geriatric assessment is still needed in TAVI candidates at low surgical risk

Sigue siendo necesaria la valoración geriátrica integral de los pacientes con bajo riesgo quirúrgico candidatos a TAVI

To the Editor,

As we read with great interest in the article by Gutiérrez et al.,[1] comprehensive geriatric assessment (CGA) is the diagnostic procedure used in elderly patients to determine their general health status in a way that goes beyond simply their clinical diagnosis. CGA involves an assessment of functional status, cognitive capacity, and social situation, and allows the development of a personalized care plan adapted to each elderly patient. CGA has also been demonstrated to be useful as a prognostic marker and follow-up or monitoring tool in this age group. The assessment includes screening for geriatric syndromes, such as cognitive or functional decline, altered sensory perception, incontinence, and frailty. Frailty in particular has been at the forefront of cardiogeriatrics and has been demonstrated to be a useful prognostic factor in elderly patients who are candidates for interventional procedures such as transcatheter aortic valve implantation (TAVI).

In this context, assessment of frailty has been helpful when it comes to choosing the best treatment option for patients with increased surgical risk, those with the greatest frailty being the best candidates for less invasive procedures compared with conventional surgical procedures. However, the therapeutic indications are undergoing changes, which warrants reflection. Recent publications, such as the PARTNER 3 clinical trial, have shown that patients with low or moderate surgical risk could benefit from TAVI with the same efficacy as conventional surgery.[2] Therefore, is frailty assessment still necessary in elderly patients who do not have a high surgical risk? The answer can only be "yes", for several reasons: first, the scales for assessing surgical risk that are used prior to TAVI do not provide a good measure of functional status, even though the World Health Organization states that functional ability is the most important parameter of quality of life in elderly individuals and the scientific evidence demonstrates its value as a prognostic marker in elderly patients, including those with heart disease. Second, the value of surgical risk scales in estimating prognosis is restricted to morbidity and mortality; they do not assess quality of life, which again is determined by the patient's functional status. Lastly, the prognostic value of CGA has already been demonstrated in elderly patients with high surgical risk who are candidates for TAVI. It is reasonable to assume that those who have a lower surgical risk are likely to have fewer comorbidities, but this does not negate the need for an assessment of the factors that are inherent to elderly patients: their functional status and independence in daily living, as well as their and their family's expectations, which are key in treatment planning. If we do not know how our patients manage in their environment, how cognitive decline affects their day-to-day life, and what care network they will have when they are discharged from hospital, we cannot really know what their best treatment option will be.

We therefore welcome the issuing of new treatment indications that advocate treatment involving the least possible harm, but in the case of elderly patients, in whom *function* and *health* go hand in hand, we must opt for a comprehensive preoperative assessment that is not limited to surgical risk. Here, multidisciplinary cardiology teams that include geriatricians can provide this additional quality to optimize elderly patients' care, since, in addition to the intervention itself, they can help minimize the functional deterioration associated with hospital admission, manage decompensated comorbidities, and ensure continuity of care upon discharge.

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