Frailty Syndromes: should wounds be considered an additional syndrome?

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Discussing chronic wounds, Ferris and Harding (2020) proposed that chronic wounds could be considered an additional frailty syndrome based partly on the notion of skin failure (Langemo and Black 2010) in older age, as well as the impact of concomitant conditions that impact wound healing. This presents an interesting viewpoint when you consider that the other five frailty syndromes include falls, immobility, delirium, incontinence and susceptibility to side effects of medication (Turner, 2014). It is not uncommon to be treating an individual with a wound that was originally sustained as an injury related to a fall or trip, for example a skin tear which if not treated promptly can develop into a hard-to-heal, chronic wound. Equally immobility is the highest risk factor for pressure ulcers (PU) and incontinence is a risk factor for moisture associated skin damage (MASD). Lastly side effects of medication such as corticosteroids and immunosuppressants can delay wound healing by delaying inflammatory cells responses, as well as granulation tissue formation. These aspects support the idea that the presence of a chronic wound might also be representative of frailty.

The global syndrome of 'frailty', represents a decreased physiologic reserve, (Rockwood and Mitnitski (2007). In combination with the impact that comorbidities can have on an individual, in particular an increased vulnerability to poorer health outcomes (Espaulella-Ferrer et al, 2021), a clear picture begins to emerge of many of the patients seen in clinical practice who may be in a cycle of physiological frailty exacerbated by other conditions including the presence of a chronic wound. So how can we improve the identification of frailty in individuals with chronic wounds? I'm sure it won't surprise you if I say that assessment is key, but how should frailty be assessed? There are specific tools to diagnose and assess frailty but these need to be used by trained health and social care individuals to ensure the assessment is accurate as there is a risk of misdiagnosing or even missing aspects of frailty syndrome. Early warning signs or indicators of frailty in a patient with a wound that should trigger an assessment are represented in the following scenario.

Think about an older person (aged 65+) that you may have cared for, they are being managed for recurrence of a venous leg ulcer (VLU). This person was previously mobile, very steady on their feet, able to attend the clinic for compression bandage changes and very communicative. At the next clinic visit you notice that their gait is more unsteady, there are signs of urinary incontinence and they're less coherent than usual. There is an overall sense that 'something's not quite right.' It's likely that based on your concerns you would make a referral to the patient's GP in the first instance that is of course the most appropriate course of action. However, the referral should make specific mention of the need for a Comprehensive Geriatric Assessment (CGA; British Geriatrics Society, 2019) as this would help to establish the individual's medical, psychological and functional capabilities to facilitate the development of a coordinated and integrated plan of care (NICE 2016). You might be thinking, but isn't this reflective of what multidisciplinary teams (MDT) do anyway? I would argue not necessarily, as MDT do not always function in an interdisciplinary/interagency way, instead the focus may be on what the different health and social care professionals can offer within a team. In contrast, the CGA process considers specific domains including; physical assessment, functional, social and environmental assessment, psychological components and a medication review (British Geriatric Society, 2019). Identification of frailty at an earlier stage could help to mitigate or even prevent issues at a later stage (Ferris and Harding 2020).

My own observations are that in relation to individuals with wounds there is a positive move towards multidisciplinary team (MDT) working, person-centred care and promotion of shared decision-making. However I think we may be

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missing early signs of frailty in some patients, or perhaps these signs are recognised but we may not be making the best use of our health and social care colleagues who are trained in the assessment of frailty and who could make a positive contribution to early interventions and long-term support of this syndrome. You may be reading this and thinking, but we are doing this! If so then please get in touch to tell us what you're doing in this area, we'd love to be able to share examples of good practice and case studies that reflect management of frailty in individuals with wounds. WUK

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