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Letter to the Editor

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EVALUATION OF THE RELATIONSHIP BETWEEN FRAILTY, POLYPHARMACY, AND DEPRESSION IN PEOPLE 65 YEARS OF AGE AND OLDER

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Dear Editor,

I am writing to you regarding the recent publication of the article titled "Evaluation of the Relationship between Frailty, Polypharmacy, and Depression in People 65 Years of Age and Older" in Ankara Medical Journal.1

I would like to begin by commending the authors for their valuable contribution to the field. As a geriatrician, I am pleased to observe an increasing recognition among family medicine doctors of the importance of frailty and its adverse impacts on the health and well-being of older adults. Additionally, geriatricians frequently assess older adults attending geriatric outpatient clinics at tertiary hospitals, such as university hospitals or training and education hospitals. Therefore, this article is also valuable for understanding the characteristics of older adults seeking care from family medicine healthcare providers.

However, the study lacks data on the prevalence of frailty and depression within the cohort, which is crucial for understanding the extent of these geriatric syndromes and comparing them with other studies. Although Table 1 of the article mentions that 13 out of 135 individuals with comorbidities were diagnosed with depression, it fails to provide the depression rate determined by the Geriatric Depression Scale (GDS). Additionally, the absence of cut-off values for the Edmonton Frailty Scale (for example, 0-5 points, 6-7 points, and 8-17 points indicate fit, vulnerable, and frail adults, respectively) and Yesavage GDS (<5 and ≥5 points indicate no depression and the possibility of depression, respectively) in the methods section may pose challenges for interpreting the results, especially for readers unfamiliar with these scales.2,3 Moreover, detailing participants' functionality, malnutrition, cognition, and continence, as these factors are closely linked to frailty, would have been beneficial. The authors already had the results of these parameters via the Edmonton Frailty Scale, which includes the clock drawing test, timed-up-and-go-test, and questions about weight loss, functional dependence, and incontinence. If the authors had shared this data, it would have allowed for a more comprehensive understanding of the cohort's structure and aided in accurately interpreting the study's findings. Implementing these recommendations in future studies involving older adults can enhance the results and contribute to identifying factors associated with geriatric syndromes.

In conclusion, it's important to recognise the vital role of family doctors, alongside geriatricians, in the care of older adults. First, their long-term relationships with patients enable them to provide personalised and comprehensive care tailored to individual needs. Second, they prioritise preventive care, including health screening, immunisation, lifestyle counselling, and chronic disease management, to promote health and independence in older people. Third, they act as central care coordinators, ensuring seamless integration and management of all aspects of healthcare. Finally, their accessibility provides valuable support and guidance to older adults and their families throughout the ageing process. Collaboration between primary care physicians and geriatricians is essential to provide the highest quality of care for older adults.

Thank you for the opportunity to provide feedback.

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