

Letter to the Editor

The clinical frailty score should not be used to assess mortality and outcomes of ICU patients

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Article Info

Keywords: Clinical frailty score, ICU, outcome, mortality, APACHE score**Received:** 12.07.2025**Accepted:** 20.08.2025**Published:** 28.08.2025

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We were interested to read the article by Saxena et al. [1], on a prospective observational cohort study on the validity of the clinical frailty score (CFS) as an outcome and mortality prediction tool in 166 ICU patients, conducted between April 23 and September 20, 2023 [1]. Frailty (CFS >5) was present in 40% of patients, increasing CFS by one unit was associated with a 42% higher mortality rate and a 51% higher probability of a negative net outcome [1]. It was concluded that the CFS is a reliable tool for predicting outcome in the ICU and is better than conventional outcome scores [1]. The study is noteworthy, but several points should be discussed.

The first point is that the CFS is not an ideal measure for assessing the mortality and outcome of ICU patients. The CFS captures only a single point in time and may not fully reflect changes in a patient's condition [2]. In addition, it relies on clinical judgment, which can lead to subjectivity and potential bias, and may not be suitable for people with dementia [2]. Another disadvantage of the CFS is that the score is not validated for pre-existing permanent disability [2]. Therefore, we should know how many of the included patients suffered from a pre-existing disability. These patients should be excluded from the analysis. Furthermore, the CFS should not be used as an isolated test, but only as part of a holistic approach and consensual multiprofessional decisions [3].

The second point is that the CFS was only applied once within 48 hours of admission to the ICU and was not repeated. Since the CFS may vary between admission and discharge, it would be interesting to know how many patients' CFS changed over the course of their ICU stay. In addition, the CFS was not tested for within- and between-observer variability. Due to the subjectivity of the score, different raters are likely to obtain different scores.

The third point is that the median number of days in the hospital was equal to the median number of days in the ICU, suggesting that either all patients were discharged home directly from the ICU or that they died in the ICU. We should know why ICU patients were not transferred to the regular ward. Since 50% were discharged from the ICU and 46% died within three weeks of discharge from the ICU, we should know what happened to the remaining patients.

The fourth point is that the current medication in the intensive care unit was not included in the analysis. This is crucial because the outcome may depend heavily on the type, dosage, pharmacodynamics, pharmacokinetics and tolerability of the medication used. Important factors influencing morbidity and mortality may have been overlooked. As the study was conducted during the pandemic [1], we should also know how many of the included patients were infected with SARS-CoV-2, how many had side effects of the vaccination and how this influenced the outcome.

Overall, the CFS should be used with caution as it has several disadvantages and can therefore lead to bias.

Declarations

Ethical approval: Not applicable

Consent to participation: Not applicable

Consent for publication: Not applicable

Funding: None received

Availability of data and material: All data are available from the corresponding author.

Competing interests: The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Author contribution: JF was responsible for the design and conception, discussed available data with coauthors, wrote the first draft, and gave final approval. SZ: contributed to literature search, discussion, correction, and final approval.

Acknowledgments: None

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