

1 How do we avoid over-treating skin cancer in people with severe frailty and 2 limited life expectancy?

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23 ***Offer routine screening for frailty to all patients aged ≥ 65 years being considered for***
24 ***management of skin cancer using a validated tool such as the Rockwood Clinical Frailty***
25 ***Scale (CFS) as advised by the British Geriatrics Society (BGS) and the Centre for***
26 ***Perioperative Care.***

27 Guidelines for managing skin cancers and precancerous skin lesions state 'no treatment (expectant
28 care)' or 'active observation' are acceptable options to be discussed with patients, where appropriate.<sup>1-
29 3</sup> However, one has to firstly identify patients for whom this discussion is most relevant. USA data show
30 that thousands of basal cell carcinomas (BCCs) are excised in people within the last few years of their
31 lives and for whom there may be little or no symptomatic or curative benefit.⁴

32 We must improve how we identify patients for whom the risks of any given skin cancer treatment are
33 likely to outweigh the benefits, and frailty scoring is central to this. Frailty is an age-associated
34 syndrome which occurs due to accumulated deficits across physical and cognitive parameters. Frailty
35 increases the risk of falls, delirium, hospital and care home admission and death, even after minor

1 events, e.g. infection or a change in medication. The BGS defines frailty as a state of increased
2 vulnerability predisposing to poor resolution of homeostasis after a stressor event. Frailty affects
3 around 10% of those aged ≥ 65 years, rising to 25-50% of those over 85, therefore, affecting a very large
4 proportion of the UK skin cancer population.⁵ A diagnosis of frailty predicts an increased risk of both
5 moderate and severe postoperative complications, and perioperative death.^{6,7} Despite this, frailty is
6 often not reported in skin cancer trials or given appropriate prominence in skin cancer clinical
7 guidelines.

8 Frailty assessment helps identify patients most vulnerable to complications and may help identify
9 patients with limited life expectancy (LLE), who are less likely to benefit from intervention for their skin
10 cancer. This assessment further informs the consideration of risks and benefits of treatment being
11 considered, supporting shared decision-making, and informing individualised management plans. This
12 should naturally lead to information which, along with tumour-specific factors, allows consideration
13 with patients of the management options available, including when no treatment, less invasive
14 treatments, treatment aimed at symptom control rather than cure or active observation/surveillance
15 strategies may be reasonable choices.

16 Although 'comprehensive geriatric assessment' is the gold standard for diagnosing and managing
17 frailty, several validated tools are available for identification of frailty.⁸ In Table 1, some of the available
18 tools are compared. The BGS recommends the use of CFS for screening or case finding, which is
19 emphasised in other guidance relevant to UK dermatology practice: the Centre for Perioperative Care
20 and the Joint Collegiate Council for Oncology. Frailty assessments should be completed early in the
21 treatment pathway. The NHS General Practice 2017/18 contract introduced routine frailty
22 identification for all patients aged ≥ 65 years with the NHS in England being the first health system to
23 introduce systematic screening for frailty.⁹

24 Defining 'with limited benefit' is critical and requires consideration of both tumour and patient factors.
25 The risks and morbidity associated with treatments vary depending on many tumour-related factors
26 such as size and location, and different skin cancers vary greatly in their behaviour, metastatic
27 potential and symptomology. The risks of gold-standard, curative treatment versus no treatment, and
28 all options in-between vary accordingly.

29 A holistic discussion of patient needs and interests, including recognition of frailty, must be central to
30 MDT recommendations; equally, frailty should not be an excuse to withhold treatment where it is
31 needed. We should all aspire to individualised treatment decisions that neither over- nor under-treat
32 whilst considering the views of the patient and family/carers.

33 With an increasingly older population with greater frailty, and the rise in skin cancer incidence,
34 managing this thoughtfully, sensitively, responsibly and consensually is important. We recommend
35 routine screening for frailty in all patients aged ≥ 65 years being considered for management of skin
36 cancer using a validated tool such as the CFS as advised by the BGS. It is likely that the ongoing
37 accumulation of data will better inform this increasingly pertinent issue in more detail. However, we
38 should now reflect on our current clinical practice when managing skin cancers and our ability to
39 identify patients with frailty/LLE in this context.

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29 **Figure legend**

30 **Figure 1.** Rockwood Clinical Frailty Scale. Reprinted from "Using the Clinical Frailty Scale in Allocating
31 Scarce Health Care Resources," by Rockwood K and Theou O, 2020. *Canadian Geriatrics Journal*. 23(3),
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Screening tool	Measures	Interpretation	Notes
Rockwood Clinical Frailty Scale (CFS) (Figure 1)	Combines clinical judgment with objective measurements, evaluates specific domains including comorbidity, function, and cognition; requires formal clinical assessment. Only validated in those aged ≥ 65 years.	Frailty scale ranging from 1 (very fit), 5 (mildly frail – more evident slowing, needing help in high order activities of daily living) to 9 (terminally ill). A score of 4 indicates those who are vulnerable/pre-frail.	App available to download. Degree of frailty corresponds to degree of dementia. Widely used and universal language of frailty in the UK.
FRAIL score	Five items contributing to increasing patient frailty: fatigue, resistance, ambulation, illnesses and loss of weight.	The FRAIL scale ranges from 0 to 5 and indicates frail (3-5), pre-frail (1-2), or robust health (0) status	Does not quantify frailty
Electronic Frailty Index (eFI)	Population risk stratification tool rather than a clinical diagnostic tool with 36 deficits used	Score 0 to 0.12 classified as fit, >0.12 to 0.24 mild frailty, >0.24 to 0.36 moderate frailty, >0.36 severe frailty, 0.7 incompatible with life	Modified for use within the NHS where information retrieved automatically from medical records in primary care
PRISMA-7	Seven items, including age (>85) and sex (male)	Three or more positive answers is indicative of frailty	Suitable for self and postal completion, brief, simple, recommended by the British geriatrics Society
Edmonton Frail Scale (EFS)	Eleven items on the EFS represent nine aspects of health cognition, general health status, social support, medication use, mood, continence and timed up-and-go test	Scored out of 17, a score of 5 or less indicates non-frail, 8-9 mild frailty, 10-11 moderate frailty and 12-17 severe frailty	The EFS website is an excellent frailty resource regarding and including a training module on delivering the score https://edmontonfrail.org/
Geriatric 8 (G8) score	A screening tool containing 8 questions including declining food	Scores between 0 and 17. A higher score indicates a better	Easy and quick to administer, consensus

	intake, weight loss, age, number of medications taken, diagnosis of dementia or depression	health status, and a score ≤ 14 is considered abnormal.	recommendation by group of skin cancer experts for frailty screening in dermatology practice
Groningen Frailty Indicator and PRISMA-7 Questionnaires	15- and 7-point scoring system to screen for (but not diagnose) frailty	Scores of >4 and >3 , respectively, indicate likely frailty and suitable for further assessment	Both suitable for self-completion, including as a postal questionnaire
Timed Up-and-Go 'TUG' test and Gait speed test	Dynamic tests - 'TUG' test a measurement of the time in seconds for a person to rise from sitting from a standard armchair, walk 3 metres, turn, walk back to the chair, and sit down	Depends on time taken to complete tests - if TUG test takes over 12 seconds, then mobility may be considered impaired	Assess walking and balance, can be delivered in <5 minutes, and no special equipment needed. Also recommended by the British Geriatrics Society as a simple test for identifying frailty.

1 **Table 1.** Comparison of frailty screening/scoring tools.

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1 **Appendix 1 - British Association of Dermatologists' Clinical Standards Unit and guideline**
2 **development groups for managing people with cutaneous squamous cell carcinoma, basal cell**
3 **carcinoma, squamous cell carcinoma in situ, Merkel cell carcinoma and actinic keratosis**

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CLINICAL FRAILITY SCALE

	1	VERY FIT	People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.
	2	FIT	People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally , e.g., seasonally.
	3	MANAGING WELL	People whose medical problems are well controlled , even if occasionally symptomatic, but often not regularly active beyond routine walking.
	4	LIVING WITH VERY MILD FRAILITY	Previously "vulnerable," this category marks early transition from complete independence. While not dependent on others for daily help, often symptoms limit activities . A common complaint is being "slowed up" and/or being tired during the day.
	5	LIVING WITH MILD FRAILITY	People who often have more evident slowing , and need help with high order instrumental activities of daily living (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.
	6	LIVING WITH MODERATE FRAILITY	People who need help with all outside activities and with keeping house . Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.
	7	LIVING WITH SEVERE FRAILITY	Completely dependent for personal care , from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).
	8	LIVING WITH VERY SEVERE FRAILITY	Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.
	9	TERMINALLY ILL	Approaching the end of life. This category applies to people with a life expectancy <6 months , who are not otherwise living with severe frailty . Many terminally ill people can still exercise until very close to death.

SCORING FRAILITY IN PEOPLE WITH DEMENTIA

The degree of frailty generally corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

In **very severe dementia** they are often bedfast. Many are virtually mute.

Clinical Frailty Scale
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Figure 1
140x216 mm (x DPI)