



ORIGINAL ARTICLE

Reproducibility and validity of the Portuguese Edmonton Frail Scale version in cardiac surgery patients



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KEYWORDS

Frailty screening;
Edmonton Frail Scale
Portuguese version;
Cardiac surgery;
Portugal;
Validity;
Reproducibility

Abstract

Introduction: Frailty is a multidimensional syndrome characterized by the loss of functional reserve, associated with higher mortality and less functional survival in cardiac surgery patients. The Edmonton Frail Scale (EFS) is a comprehensive tool devised for brief frailty detection. To the best of our knowledge, there are no culturally adapted and validated frailty screening tools that enable the identification of vulnerability domains suited for use in the preoperative setting in Portugal. This was the motivation for this study.

Objectives: To assess the validity and reproducibility of the Portuguese version of the EFS.

Methods: Prospective observational study, in a sample of elective cardiac surgery patients. The Edmonton Frail Scale (EFS) translation and backtranslation were performed. Demographic and clinical data were collected, and the translated EFS translated, Geriatric Depression Scale, and Mini Mental State Examination Portuguese versions, Katz and Clinical Frailty Scales were administered. To assess validity Mann–Whitney test, Spearman's correlation coefficient, marginal homogeneity test and Kappa coefficient were employed. Reproducibility was assessed estimating kappa coefficient for the frailty diagnosis and the 11 EFS items. Intra-class correlation coefficients and the corresponding 95% confidence interval were estimated using linear mixed effects model.

Results: The EFS Portuguese version revealed construct validity for frailty identification, as well as criterion validity for cognition and mood domains. Reproducibility was demonstrated, with $k=0.62$ (95% confidence interval (CI) 0.42–0.82) and intraclass correlation (ICC)=0.94 (95% CI 0.89–0.97) in inter-observer test and $k=0.48$ (95% CI 0.26–0.70) and ICC=0.85 (95% CI 0.72–0.92) in intra-observer test.

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PALAVRAS-CHAVE

Rastreo de fragilidade; Versão Portuguesa da *Edmonton Frail Scale*; Cirurgia cardíaca; Portugal; Validade; Reprodutibilidade

Conclusions: The EFS Portuguese version is valid and reproducible for use, suiting pre-operative frailty screening in a cardiac surgery setting.

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Reprodutibilidade e validade da Versão Portuguesa da Escala de Fragilidade de Edmonton em doentes de cirurgia cardíaca

Resumo

Introdução: A fragilidade é uma síndrome multidimensional caracterizada pela perda de reserva funcional, associada a maior mortalidade e menor sobrevivência funcional após cirurgia cardíaca. A Escala de Fragilidade de Edmonton (EFS) é uma ferramenta abrangente de deteção de fragilidade. Não existe ainda em Portugal uma ferramenta de rastreo culturalmente adaptada e validada que permita a identificação de domínios específicos de vulnerabilidade para utilização no pré-operatório.

Objetivos: Avaliar a validade e reprodutibilidade da versão portuguesa da EFS.

Métodos: Estudo prospetivo observacional, realizado numa amostra de doentes propostos para cirurgia cardíaca. A EFS foi traduzida e retrotraduzida. Colheram-se dados demográficos e clínicos, aplicaram-se as versões traduzidas da EFS, Escala de Depressão Geriátrica e MMSE, as escalas de Katz e *Clinical Frailty Scale*. Validade avaliada utilizando o teste de Mann-Whitney, o coeficiente de correlação de Spearman, o teste de homogeneidade marginal e o coeficiente Kappa. Reprodutibilidade avaliada pelo cálculo do coeficiente kappa para o diagnóstico de fragilidade e para os 11 itens da escala. Coeficientes de correlação intraclasse e correspondentes intervalos de confiança a 95% estimados usando um modelo linear de efeitos mistos.

Resultados: A versão portuguesa da EFS demonstrou validade de constructo, assim como validade de critério nos domínios de cognição e humor. É reprodutível, com $k=0,62$ (95% IC 0,42-0,82) e $CCI=0,94$ (95% IC 0,89-0,97) no teste interobservador e $k=0,48$ (95% IC 0,26-0,70) e $CCI=0,85$ (95% IC 0,72-0,92) no teste intraobservador.

Conclusões: A versão portuguesa da EFS é adequada para rastreo pré-operatório de fragilidade em cirurgia cardíaca.

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Introduction

Frailty is a multidimensional syndrome characterized by the loss of functional reserve. It increases a person's vulnerability to adverse events when exposed to even minor stress. There is increasing evidence that regardless of the tool used, frailty assessment before major surgery adds value to predict post-operative mortality, complications and length of stay.¹⁻³

Specifically, in a cardiac surgery setting the changing demographics and surgical case mix over the last 20 years has had implications on conventional risk scores performance and calibration (observed–expected mortality ratio) over time.⁴ Different frailty screening tools have been used before cardiac surgery and showed to outperform the EuroSCORE and Society of Thoracic Surgery (STS) scores in mortality prediction.^{5,6} It is currently accepted that frailty is associated with higher mortality in elderly people with cardiovascular disease and less functional survival in cardiac surgery patients.⁵⁻⁷ However, the value of systematic frailty screening before surgery is not limited to better prognostic

performance, it has also implications for adequate planning of care and clinical governance, especially if the tool in use enables the identification of vulnerability domains amenable to preoperative intervention and optimization.⁷

The most accepted diagnostic tool for frailty is the Comprehensive Geriatric Assessment (CGA) performed by gerontologists. However, it is time consuming and requires special training, which makes it difficult to apply in a preoperative setting. The Edmonton Frail Scale (EFS) is a comprehensive tool (nine domains, eleven items) devised for brief frailty detection that can be applied in a busy preoperative setting. It allows frailty quantitative stratification and has been used for frailty screening and as a prognostic tool both in inpatient and outpatient settings.⁷⁻⁹

Objectives

This study aimed to assess the reproducibility and validity of the culturally adapted Portuguese version of the Edmonton Frail Scale in a population of elective cardiac surgery

patients, in whom frailty is being studied as a potential prognostic factor.

The reproducibility of a tool is particularly important when there are many different tools in use, and no single gold standard, as is the case with frailty screening. It can be applied by different investigators to the same subject (inter-observer reproducibility) or by the same investigator to the same subject at two different times (intra-observer reproducibility).¹⁰

The validity of a tool refers to how well a measurement describes the phenomena of interest. Construct validity addresses how well a measuring tool agrees with a theoretical construct.¹⁰ Frailty is conceptualized as multidimensional loss of reserve and increased vulnerability to stressors. As a multidomain tool, the Edmonton Frail Scale, captures frailty multidimensional nature, distinguishing it from disability, cognitive deficit or aging alone. Criterion validity represents the degree to which a measure correlates with accepted existing measures.¹⁰ To assess criterion validity for P-EFS, Clinical Frailty Scale, another frailty screening tool, was used.

Additionally, to the best of our knowledge, there are no adapted and validated frailty screening tools currently used in the preoperative setting in Portugal, which led us to perform this study.

Methods

Study design and subjects

This study was approved by the NOVA Medical School/Faculdade de Ciências Médicas and Centro Hospitalar Universitário de Lisboa Central (CHULC) prior to initiation. We conducted a prospective observational study of consecutive elective cardiac surgery patients between July 2016 and November 2018, who were followed up for one year, and will be the subject of a different manuscript. To calculate the larger study sample size, an $\alpha=0.05$, an error of 0.04 and a frailty prevalence of 15% were considered, achieving a sample size of 306 patients.^{11,12} At our institution, all elective cardiac surgery patients are observed in preoperative anesthesia consultations. Patient recruitment took place once the nature and goals of the study had been explained and consent for data collection obtained. A convenience sample of consecutive patients 65 years old and above, admitted for elective valve or myocardial revascularization surgery and observed by the principal investigator in preoperative anesthesia consultation, was selected. For the purpose of validity and reproducibility studies, we estimated subsamples of 139 and 64 patients, respectively (detailed ahead). Exclusion criteria were complex aortic arch procedures, urgent or redo surgery, and the presence of sensory or cognitive deprivation that prevented communication between patients and investigators. [Figure 1](#) depicts the flowchart from enrolled patients for the prospective longitudinal, validity and reproducibility studies.

Translation and cross-cultural adaptation methods

Prior to reproducibility testing and after obtaining permission from the EFS authors, the original English version of the EFS was translated to Portuguese by two independent translators. A group of eight doctors from different specialties (anesthesiologists, cardiac surgeons, and family physicians) with knowledge of the frailty construct met in a focus group to build a final consensus Portuguese version. Both the final Portuguese version and its English backtranslation were sent to the original authors for approval. The original English and Portuguese versions, licensed by the University of Alberta for use in this study, are depicted in [Figures 2 and 3](#).

Prior to the start of the study, the principal investigator administered the Portuguese EFS adapted version to ten eligible patients to identify possible difficulties with its use and contacted the original authors to clarify any doubts that arose. Subsequently, another two collaborators were trained by the principal investigator to administer the scale.

Reproducibility and validity study

The maximum scoring for EFS is 17 and cut-points proposed in the official 2019 EFS webpage were considered in frailty diagnosis (1–3 fit; 4–5 vulnerable; 6–7 mild frailty; 8–9 moderate frailty; 10 or more severe frailty).

Other pre-defined variables were collected as part of the larger study, including demographic and clinical variables, such as number of school years, marital status, main surgical diagnosis, and scores in the Portuguese adapted versions of the Mini-Mental State Examination (MMSE)^{13,14} and Geriatric Depression Scale (GDS),¹⁵ as well as Katz¹⁶ scale and Clinical Frailty Scale (CFS)¹⁷ scores. In addition, the prognostic scores EuroSCORE II¹⁸ (European System for Cardiac Operation Risk Evaluation) and STS^{19,20} were collected.

To test for reproducibility of the P-EFS adapted version and assuming that good agreement would be a Kappa coefficient >0.60 or an intraclass correlation coefficient >0.8 ,²¹ an $\alpha=0.05$ and a $\beta=0.10$ (power of 0.90), we estimated a sample size of 30 subjects. To avoid exposure to the P-EFS related bias, we more than doubled the sample size and performed 34 inter-observer and 33 intra-observer agreement tests in 64 patients. P-EFS was re-applied within a minimum interval of 2 h and a maximum of 2 months. A substantial part of the enrolled patients lived more than 50 km away from the hospital and/or were not totally autonomous in traveling to the hospital. Therefore, the research team agreed to administer P-EFS at patients' scheduled appointments for routine and essential examinations for preoperative assessment, and no patient returned exclusively for the purpose of P-EFS re-administration.

To test for construct and criterion validity, 139 patients provided at least 0.80 power (effect size=0.4 and $\alpha=0.05$, two-sided test) to detect differences among groups.

To assess construct validity, we evaluated the agreement of Katz and MMSE measurements with P-EFS total scores, and regarding criterion validity we compared P-EFS and Clinical Frailty Scales scores. The

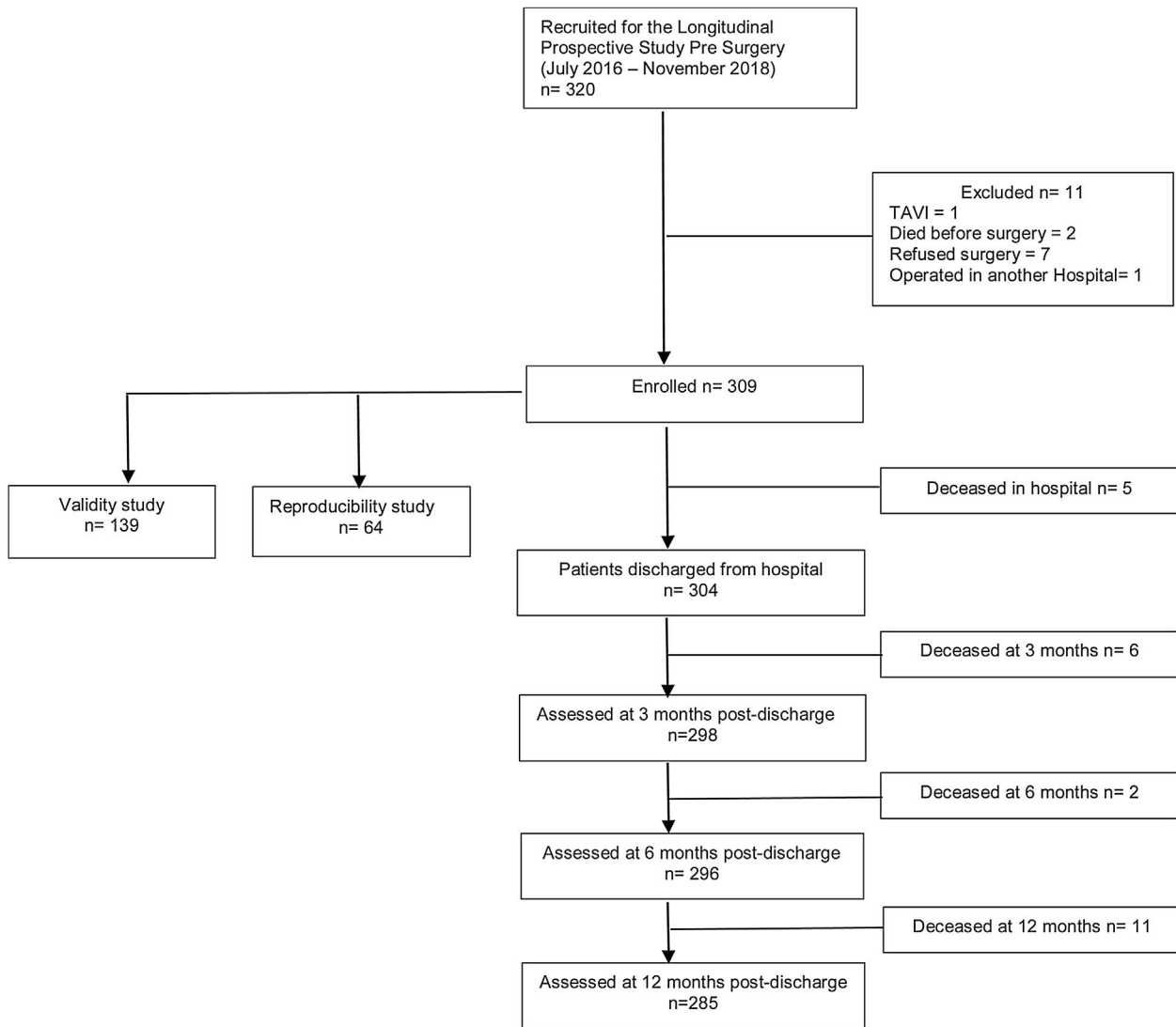


Figure 1 Flowchart of enrolled patients.

Clinical Frailty Scale has been widely used both in outpatient and acute care settings. It is an ordinal scale that incorporates clinician judgment and employs a 1–9 scoring system that includes the evaluation of many frailty domains. It stratifies frailty into fit (1–3), vulnerable (4), frail (5–8) and terminally ill (9) (Figure 4). For P-EFS specific domains of cognition and mood, we assessed criterion validity by comparing the Clock Drawing Test with MMSE and Mood questions in P-EFS with GDS30 and GDS 15.

Regarding MMSE normative data, we used both Morgado et al.'s¹³ cut-off points for cognitive deficit, as they are the most widely accepted by the Portuguese medical community, and the more recent Freitas et al.¹⁴ normative data.

Content validity assessment was not performed as it would require the CGA of study participants to establish a frailty diagnosis, and this is not part of a standard preoperative evaluation in clinical practice. On the other hand, the content validity for the EFS was established by the authors of the original version when it was first described.

Statistical analysis

The characteristics of study participants were described with frequencies (percentages) and with median and range (min–max), as appropriate. The Mann–Whitney test, Spearman's correlation coefficient, marginal homogeneity test, and Kappa coefficient were used as needed to assess validity.

For reproducibility assessment, the Kappa coefficient was estimated for both frailty diagnosis and the 11 EFS items in inter- and intra-observer analyses. To assess the intra-observer repeatability and inter-observer reproducibility, intraclass correlation coefficients (ICCs) and corresponding 95% confidence intervals were estimated using linear mixed-effects models.

The level of significance was set at $\alpha=0.05$. Data were analyzed using the Statistical Package for the Social Sciences for Windows (version 25.0; IBM Corp. Released 2017. IBM SPSS Statistics for Windows, version 25.0. Armonk, NY: IBM Corp.).

The Edmonton Frail Scale
 Bedside Version

Date: _____ B $\times 1 =$ _____
 Examiner: _____ C $\times 2 =$ _____
 Additional Source: _____ Total Score: _____

PATIENT IDENTIFICATION

Scoring the EFS	FIT	VULNERABLE	MILD	MODERATE	SEVERE
	1 2 3	4 5	6 7	8 9	10+
	FRAILTY				

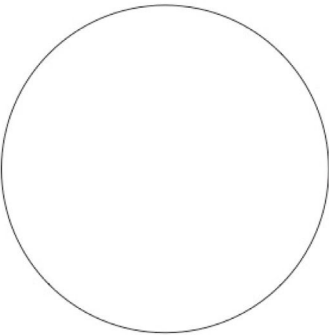
Questions: A B C
 A=0 B=1 C=2

1. Cognition

Clock Drawing Test
 "Please imagine that this circle is a clock. I would like you to place the numbers in the correct positions, then place the hands to indicate a time of ten after eleven."

PASS FAIL WITH MINOR ERRORS FAIL WITH MAJOR ERRORS

Fold at the dotted line before asking the patient to start in order to conceal distractors.



The Edmonton Frail Scale
 Bedside Version

2/2

Questions: A B C
 A=0 B=1 C=2

If the clock drawing test (item 1) scores in column B or C, then subsequent items marked with an asterisk* may be scored based on the best information available.

2. General Health Status

* a) In the past year, how many times have you been admitted to a hospital? 0 1-2 >2

b) In general, how would you describe your health? (Select one)
 EXCELLENT VERY GOOD FAIR POOR
 GOOD

3. Functional Independence

* With how many of the following activities do you require help?
 Meal Preparation Shopping Telephone Housekeeping
 Taking Medications Transportation Laundry Managing Money 0-1 2-4 5-8

4. Social Support

When you need help is there someone who you can count on who is willing and able to meet your needs?
 ALWAYS SOMETIMES NEVER

5. Medication Use

* a) Do you use 5 or more prescription medications on a regular basis? NO YES
 * b) At times have you forgotten to take your prescription medications? NO YES

6. Nutrition

* Have you recently lost weight such that your clothing has become loose? NO YES

7. Mood

Do you often feel sad or depressed? NO YES

8. Continence

* Do you have a problem with losing control of urine when you don't want to? NO YES

9. Functional Performance

Timed Get Up & Go Test - 3 meters
 "I would like you to sit in this chair with your back and arms resting. Then, when I say GO, please stand up and walk at a safe and comfortable pace to the place I show you, return to the chair and sit down."
 Total time recorded _____ seconds
 0-10 SECONDS 11-20 SECONDS >20 SECONDS

Score this test item as >20 seconds if:
 a) The individual is reluctant or unable to complete the test.
 b) Safe performance of the test requires a safety belt, walking aid or assistance from another person.

The Edmonton Frail Scale—Official Bedside Version © 2019 University of Alberta. All rights reserved. These materials may not be copied, published, translated, distributed, or reproduced in any way in whole or in part without license from the University of Alberta. Based on the original version © 2009 presented at the Canadian Geriatrics Society Annual Scientific Meeting, later published in abbreviated format in Rollman DB, et al Validity and reliability of the Edmonton Frail Scale. Age and Ageing 2006, 35(5): 526–529 doi: 10.1093/ageing/afk041.

Figure 2 Original English version from the University of Alberta.

Results

Validity study

In the 139 patients sample used for validity study, mean age was 73.55 years (5.84), with 57.6% male and 18.0% widowers, and a mean years of schooling of 5.49 (4.23). In the surgery group, 47.5% underwent aortic valve replacement, 30.2% to coronary artery bypass graft, 2.2% to mitral valve replacement, and the remaining patients underwent more than one surgery (Table 1). The median raw EFS score was 6, ranging from 1 to 13. Considering the EFS score in categories, 15 (10.8%) were fit (1–3), 35 (25.2%) were vulnerable (4–5), 49 (35.3%) exhibited mild frailty (6–7), 25 (18%) exhibited moderate frailty (8–9), and 15 (10.8%) had severe frailty (≥10).

The EuroSCORE II, STS Mortality, and STS Morbi-mortality, GDS30 and GDS15, MMSE, Katz, and CFS descriptive data are presented in Table 2.

Analysis of GDS30 results revealed that 63.3% of the patients had no depressive symptoms, 31.7% had mild depression, and 5% had severe depression. When GDS15 was considered, 33.1% had depressive symptoms. Regarding P-EFS mood questions, 40.3% answered “yes” when asked about sadness or depression.

Table 1 Demographic and clinical data in the validity study sample.

	Validity study sample (n=139)
Mean age (SD)	73.55 (5.84)
Sex	
Male	57.6%
Female	42.4%
Schooling years	
Mean (SD)	5.49 (4.23)
Median (min–max)	4 (0–22)
Marital status	
Married	76.3%
Widowed	18.0%
Other	5.8%
Surgery type	
CABG	30.2%
Valve surgery	56.2%
CABG+Valve	13.6%

Abbreviations: CABG: coronary artery bypass graft; SD: standard deviation.

Escala de Fragilidade de Edmonton

Versão de Cabeceira

1/2

IDENTIFICAÇÃO DO PACIENTE

Data: _____ B **x 1 =** _____

Examinador: _____ C **x 2 =** _____

Fonte Adicional: _____ Pontuação Total: _____

FORMA	VULNERÁVEL	LEGERA	MODERADA	SEVERA						
Pontuar a EFE	1	2	3	4	5	6	7	8	9	10+

FRAGILIDADE

Questões

	A	B	C
1. Cognição			
Teste do Relógio			
2. Estado Geral de Saúde			
3. Independência Funcional			
4. Suporte Social			
5. Utilização de Medicamentos			
6. Nutrição			
7. Humor			
8. Continência			
9. Desempenho Funcional			

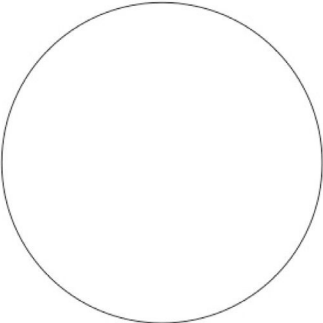
Para cada item escolha apenas uma opção na coluna A, B ou C. A pontuação é atribuída com base na coluna. Por favor veja a fita da Ferramenta EFE para instruções detalhadas.

1. Cognição

Teste do Relógio

Imagine que o círculo desenhado é um relógio. Coloque os números na posição correta e de seguida marque "onze horas e dez".

 Dobre pelo pontilhado de modo a evitar distrações antes de pedir ao doente para começar.



Escala de Fragilidade de Edmonton

Versão de Cabeceira

2/2

Questões

	A	B	C
Se o Teste do Relógio (item 1) pontua na coluna B ou C, então os itens seguintes marcados com asterisco podem pontuar com base na melhor informação disponível.	A = 0	B = 1	C = 2
2. Estado Geral de Saúde			
* a) *Durante o último ano quantas vezes é que foi internado num hospital?	0	1-2	>2
b) Em geral como é que sente que está a sua saúde? (Escolha uma)	EXCELENTE MUITO BOA BOA	RAZOVÁVEL	MÁ
3. Independência Funcional			
* Para quais das seguintes atividades precisa de ajuda?			
<input type="checkbox"/> Preparar refeições <input type="checkbox"/> Ir às compras <input type="checkbox"/> Telefonar <input type="checkbox"/> Limpar a casa	0-1	2-4	5-6
<input type="checkbox"/> Tomar medicação <input type="checkbox"/> Usar transportes <input type="checkbox"/> Tratar da roupa <input type="checkbox"/> Governar dinheiro			
4. Suporte Social			
Quando necessita de ajuda, pode contar com alguém que está disposto e é capaz de satisfazer as suas necessidades?	SEMPRE	ÀS VEZES	NUNCA
5. Utilização de Medicamentos			
* a) Toma cinco ou mais medicamentos diferentes regularmente?	NÃO	SIM	
* b) Às vezes esquece-se de tomar os medicamentos que lhe receitaram?	NÃO	SIM	
6. Nutrição			
* Perdeu peso recentemente de tal modo que a sua roupa lhe ficou mais larga?	NÃO	SIM	
7. Humor			
Costuma sentir-se frequentemente triste ou deprimido?	NÃO	SIM	
8. Continência			
* Perde urina sem querer?	NÃO	SIM	
9. Desempenho Funcional			
Teste Timed Get Up and Go - 3 metros			
*Sente-se agora nesta cadeira, com as costas e braços apoiados. Depois, quando eu disser "ANDE" levante-se e ande no seu passo habitual até à marca que está no chão, e depois volte para a cadeira e sente-se.			
Tempo total registado _____ segundos	0-10 SEGUNDOS	11-20 SEGUNDOS	>20 SEGUNDOS
Pontue este item >20 segundos se:			
a) paciente relutante ou incapaz de completar o teste.			
b) a execução segura do teste requer um auxiliar da marcha ou a ajuda de outra pessoa.			

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Figure 3 Adapted and licensed Portuguese version of the Edmonton Frail Scale.

Table 2 Description of different scores used in validity study.

Score	n=139
<i>EuroSCORE II; median (min-max)</i>	1.62 (0.64-6.48)
<i>STS Mortality; median (min-max)</i>	1.52 (0.00-11.36)
<i>STS Morbimortality; median (min-max)</i>	11.15 (3.33-40.82)
<i>GDS30 (0-30); median (min-max)</i>	8 (0-28)
<i>GDS15 (0-15); median (min-max)</i>	3 (0-13)
<i>MMSE [0-30]; median (min-max)</i>	28 (14-30)
Katz; n (%)	
1 to 5 – dependent for at least one BADL	49 (35.3)
6 – independent for all BADL	90 (64.7)
Clinical Frailty Scale; n (%)	
3 – Managing well	6 (4.3)
4 – Vulnerable	68 (48.9)
5 – Mildly Frail	53 (38.1)
6 – Moderately Frail	11 (7.9)
7 – Severely Frail	1 (0.7)

Abbreviations: BADL: Basic Activities of Daily Living; GDS: Geriatric Depression Scale; STS: Society of Thoracic Surgeons Cardiac Surgery Risk; MMSE: Mini-Mental State Examination.

Regarding criteria validity for the mood domain, the mood question in P-EFS showed good agreement ($k=0.651$, $p<0.001$) with P-GDS30 and moderate agreement with P-GDS15 ($k=0.569$, $p<0.001$).

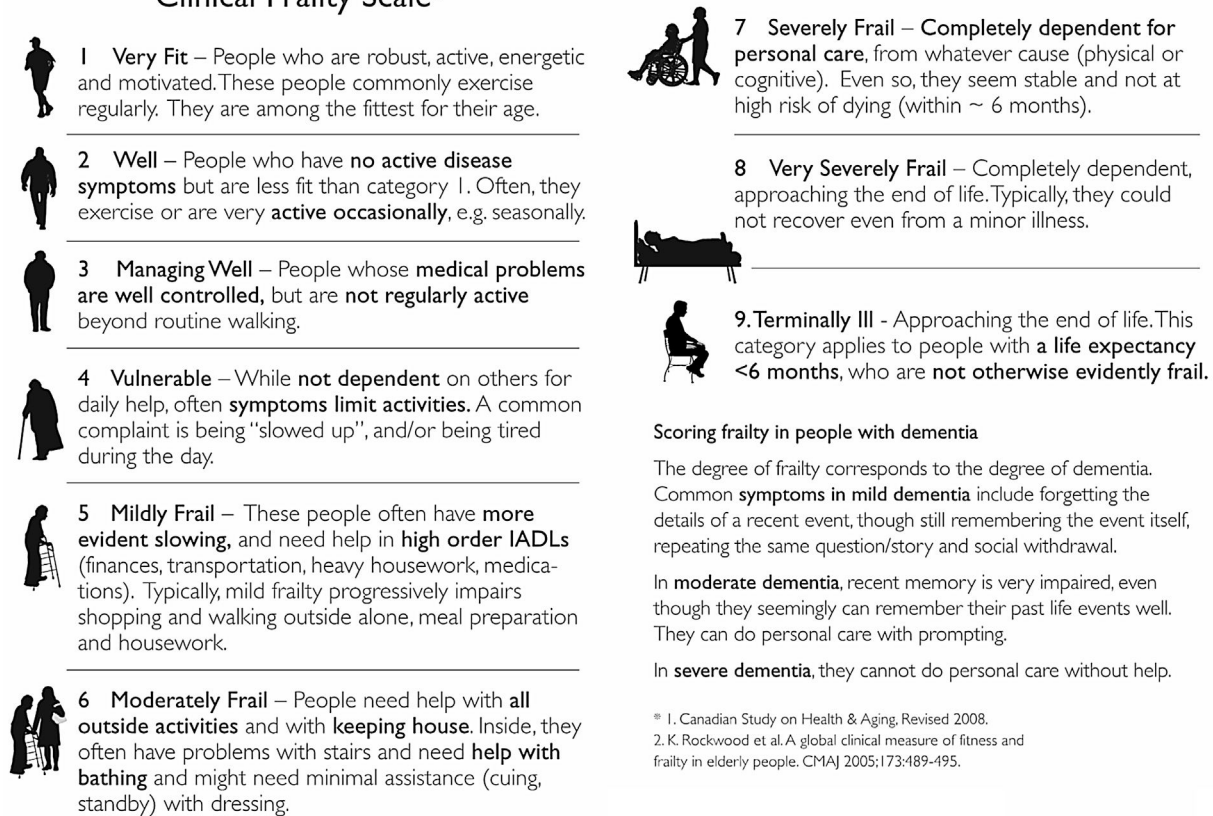
For the screening of cognitive deficits using MMSE, we considered both the 2009 and 2014 normative data for the Portuguese population. According to the 2009 criteria, only 12.2% of patients scored for cognitive deficit, but this percentage increased to 19.4% when the 2014 criteria were applied. In the validity sample and analysis of the P-EFS cognition domain, 26.6% scored for major errors in the Clock Drawing Test (CDT), and the remaining had either no errors (29.5%) or minor errors (43.9%).

Regarding criterion validity testing for the cognition domain, two categories in the CDT were considered: one composed of "no errors + minor errors" and the other "major errors", as only these are valued as cognitive deficit in the CDT. Clock Drawing Test in the P-EFS showed fair to moderate agreement with P-MMSE either considering 2014 criteria ($k=0.356$, $p<0.001$) or 2009 criteria ($k=0.422$, $p<0.001$).

Regarding criterion validity, only a fair agreement between P-EFS and CFS scores was found ($k=0.224$, $p<0.001$) and as such we could not demonstrate criterion validity for P-EFS using CFS as another accepted measure of frailty.

To test for construct validity, the P-EFS total score was compared with the Katz and MMSE scores. P-EFS total scores

Clinical Frailty Scale*



Scoring frailty in people with dementia

The degree of frailty 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.

* 1. Canadian Study on Health & Aging, Revised 2008.

2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

Figure 4 Clinical Frailty Scale.

were significantly different between patients with a Katz score of 6 (independent on all BADL) and Katz scores <6 (dependent on at least one BADL) ($p < 0.001$).

The P-EFS total score was negatively correlated with the MMSE total score (Spearman $\rho = -0.357$, $p < 0.001$) with increasing P-EFS scores associated with decreasing MMSE scores. When the 2014 and 2009 criteria for cognitive deficit were considered, a statistically significant association existed between the P-EFS total score and MMSE screening cognitive deficit ($p = 0.002$ and $p = 0.001$, respectively).

Reproducibility study

In the reproducibility study, the mean age was 74.85 (SD=6.32) years and 74.91 (SD=6.50) years in the inter-observer and intra-observer study sample, respectively, with 52.9% (inter-observer) and 48.5% (intra-observer) male, 26.5% (inter-observer) and 21.2% (intra-observer) widowers, and 84.8% (inter-observer) and 57.6% (intra-observer) with no schooling or less than 4 schooling years, respectively (Table 3).

Frailty raw scores and classified into five categories of descriptive results for the inter- and intra-observer study samples are shown in Table 4. The two measurements were obtained by two different investigator in the inter-observer study and by the same investigator at two distinct time points in the intra-observer study.

Regarding re-application of the scale, for the inter-observer test, median was 0 (P25=0; P75=1) days and mean was 3.32 (SD=10.57) days. For the intra-observer test, median was 21 (P25=7; P75=36) days and mean was 30.51 (SD=52.26).

Intra-class correlation coefficient estimates obtained with the inter- and intra-observer study samples were 0.94 (95% CI 0.89–0.97) and 0.85 (95% CI 0.72–0.92), respectively.

The kappa coefficient estimates and percentage of agreement regarding the 11 items of P-EFS and the different P-EFS categories are depicted in Table 5.

Discussion

The Portuguese EFS version was shown to have construct validity for the frailty construct.

The construct validity analysis showed a negative correlation between P-EFS and MMSE, as expected, since the two measures were inversely related. There was a significant difference in P-EFS scores between patients, with those with cognitive deficits displaying the highest P-EFS scores, considering either 2009 or 2014 normative data for MMSE. P-EFS scores were statistically different between patients totally independent of BADL compared to those dependent on at least one BADL on the Katz scale.

Regarding criterion validity, it showed only fair agreement with CFS scores. CFS is an ordinal scale, relying on clinician judgment and is more subjective in nature than

Table 3 Clinical and demographic data in the reproducibility study sample.

	Inter-observer (n=34)	Intra-observer (n=33)
<i>Mean age (SD)</i>	74.85 (6.32)	74.91 (6.50)
<i>Sex</i>		
Male	52.9%	48.5%
Female	47.1%	51.5%
<i>Schooling years</i>		
0–3 schooling years	84.8%	57.6%
>3 schooling years	15.2%	42.4%
<i>Marital status</i>		
Married	58.8%	69.7%
Widowed	26.5%	21.2%
Other	14.7%	9.1%
<i>Surgery type</i>		
CABG	35.3%	24.2%
Valve	58.8%	57.6%
CABG+Valve	5.9%	18.2%

Abbreviations: CABG: coronary artery bypass grafting; SD: standard deviation.

Table 4 P-EFS Raw Scores and classified into categories for inter- and intra-observer sample studies.

P-EFS Raw Scores and with categories	Inter-observer (n=34)		Intra-observer (n=33)	
	P-EFS1	P-EFS2	P-EFS1	P-EFS2
<i>Raw Score; median (min–max)</i>	6 (2–11)	6 (2–11)	7 (0–11)	7 (2–13)
<i>P-EFS Score categories; n (%)</i>				
Fit (1–3)	3 (8.8)	4 (11.8)	4 (12.1)	5 (15.2)
Vulnerable (4–5)	11 (32.4)	11 (32.4)	6 (18.2)	5 (15.2)
Mild frailty (6–7)	10 (29.4)	7 (20.6)	12 (36.4)	13 (39.4)
Moderate frailty (8–9)	5 (14.7)	7 (20.6)	8 (24.2)	6 (18.2)
Severe frailty (≥10)	5 (14.7)	5 (14.7)	3 (9.1)	4 (12.1)

Abbreviations: P-EFS: Portuguese Edmonton Frail Scale; EFS1 and EFS2 stand for measurements 1 and 2.

EFS, which is a quantitative scale, measuring objectively different function domains. Studies in which both scales were used to assess frailty in the same population found slightly different values for frailty prevalence.²² Although both scales have demonstrated construct validity for frailty in different settings, their essentially different nature may explain our findings showing only fair agreement between them.

For the specific domain cognition, there was moderate agreement between the Clock Drawing Test considering two categories (major errors vs. no errors+minor errors) and the presence of cognitive deficits in MMSE, according to both 2014 and 2009 normative data. For the specific domain Mood, there was good agreement between the mood question in P-EFS and either the GDS30 or GDS15 in identifying patients with depressive symptoms.

P-EFS showed to be reproducible for the studied population, with moderate to good agreement when considering intra- and inter-observer studies, respectively.

There were some differences in agreement for inter- and intra-observer analyses. Higher agreement, both in inter- and intra-observer studies, was observed in the items of

the scale that rely more on objective information or patient performance, such as the clock drawing and TUG tests, the number of admissions in hospital, the number of prescribed medications, and the questions about nutrition, continence, and mood. The lowest agreement was observed for the item “In general, how would you describe your health?” in the intra-observer study. In addition, the item “At times, do you forget to take your prescription medications?” showed moderate agreement in both the inter- and intra-observer tests. One possible explanation for the lower agreement observed is the more subjective nature of these questions.

Regarding the diagnostic categories for frailty, we observed that for the extremes of the scale, there was a coincidence between the two measurements in the frailty category. For the intermediate categories (vulnerable, mild, and moderate frailty), some patients changed category between the two measurements, with a larger proportion scoring for mild, moderate, or severe frailty in the second measurement. A possible contributing factor to this change was the interval between P-EFS re-administration. Considering the dynamic nature of frailty as a condition, it is possible that a second measurement one to two months after the first

Table 5 Kappa coefficient estimates and agreement in inter- and intra-observer study.

P- EFS item	Inter-observer Kappa	Agreement	Intra-observer Kappa	Agreement
Clock Drawing Test	k=0.73 (95% CI 0.53–0.92)	82.4%	k=0.77 (95% CI 0.58–0.95)	84.8%
In the past year, how many times have you been admitted to a hospital?	k=1.00 (95% CI 1.00–1.00)	100%	k=0.89 (95% CI 0.68–1.10)	97.0%
In general, how would you describe your health?	k=0.69 (95% CI 0.46–0.91)	82.4%	k=0.20 (95% CI –0.09–0.48)	54.5%
With how many of the following activities do you require help?	k=0.67 (95% CI 0.44–0.89)	79.4%	k=0.89 (95% CI 0.75–1.04)	93.9%
When you need help is there someone who you can count on who is willing and able to meet your needs?	k=0.90 (95% CI 0.69–1.10)	97.1%	k=0.63 (95% CI 0.16–1.10)	93.9%
Do you use 5 or more prescription medications on a regular basis?	k=0.80 (95% CI 0.52–1.06)	94.1%	k=0.87 (95% CI 0.63–1.12)	97.0%
At times, have you forgotten to take your prescription medications?	k=0.61 (95% CI 0.35–0.87)	82.4%	k=0.54 (95% CI 0.22–0.87)	81.8%
Have you recently lost weight such that your clothing has become loose?	k=0.86 (95% CI 0.67–1.05)	94.1%	k=0.87 (95% CI 0.70–1.04)	93.9%
Do you often feel sad or depressed?	k=0.82 (95% CI 0.62–1.01)	91.2%	k=0.82 (95% CI 0.62–1.01)	90.9%
Do you have a problem with losing control of urine when you don't want to?	k=0.92 (95% CI 0.77–1.07)	97.1%	k=0.91 (95% CI 0.75–1.08)	97%
Timed get up and go test (TUG Test) – 3 meters	k=0.60 (95% CI 0.35–0.85)	79.4%	k=0.73 (95% CI 0.51–0.95)	84.8%
EFS categories	k=0.62 (95% CI 0.42–0.82)	70.6%	k=0.48 (95% CI 0.26–0.70)	60.6%

Abbreviations: CI: confidence interval; k: Kappa coefficient; P-EFS: Portuguese Edmonton Frail Scale; TUG: timed up and go test.

measurement captured a slightly different health condition. The research team decided to perform repeated measures on patients' already scheduled visits to the hospital as a strategy to maximize adherence by prioritizing the patients' convenience, given their age and functional independence. Although it has optimized adherence, it may have been associated with changes in the patients' frailty, reflected in agreement.

One aspect to mention is the ease of administration of this scale. The three elements involved in EFS administration were physicians (two anesthesiologists and a graduate medical student), with interest in geriatric medicine, who did not have any previous intensive or very specific training in this field.

Conclusions

As intended by the original authors for EFS, the Portuguese adapted version was shown to be reproducible and valid for use, suiting the purpose of frailty screening in a few minutes by health professionals other than gerontologists. It enables the identification of frail patients, stratification of patients according to frailty from mild to severe, and also to identify specific domains of vulnerability, which can be addressed and optimized prior to surgery in order to benefit the patient

and improve prognosis. It also provides the health team, the patient, and its family with additional information that can be used while considering surgery and global health status in a specific patient, and therefore, make better informed decisions that represent value to the patient, to the health team, and to the system.

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Conflicts of interest

The authors have no conflicts of interest to declare.

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