Age: the least important number?

Nov 14, 2020, marked World Diabetes Day. First launched in 1991, this day was a little different in 2020. Although global incidence of type 2 diabetes continues to increase, the world’s focus is elsewhere, watching the unfolding tragedy of the COVID-19 pandemic. At first glance, the two diseases seem utterly dissimilar: one is a viral infection with unknown pathogenesis, the other a well-studied non-communicable disease. However, notably, the two share at least one aspect: both appear to increase with age.

The Lancet Commission on diabetes, published on this year’s World Diabetes Day, notes that one factor driving the global diabetes epidemic is demographic ageing: the increasing proportion of the population comprised of older people. Similarly, COVID-19 appears to have such worse outcomes for older people that some countries—including the UK—recommended that those over a certain age isolate themselves entirely as a means of protection. We accept these recommendations because it is still widely held that age alone is the determining factor in health. To be older than a certain age is seen, automatically, as being vulnerable, yet this is to confuse chronological age with something more nuanced, complex, and important: frailty.

Frailty can be defined as “a state of increased vulnerability to poor resolution of homeostasis after a stressor event which increases the risk of adverse outcomes”. In other words, it is a multi-faceted and complex clinical syndrome which acts to reduce an individual’s resilience. Data clearly show that people who are frail have worse outcomes following even minor stressors than those who are not frail. Frail people have a substantially increased risk of developing disabilities, needing long-term care, and of death.

There is a strong association between frailty and age. Frailty can develop as a consequence of age-related decline, with between 25-50% of people older than 85 years estimated to be frail. However, to be older is not automatically to be frail, despite the conflation of the two. Frailty arises from an interplay of multiple factors, including social, genetic, physiological, and environmental causes. Age, in this context, is simply another risk factor for the development of frailty.

The implications of this can be seen when looking at outcomes for patients with both diabetes and COVID-19. In this issue, we publish a systematic review and meta-analysis of frailty measurement, prevalence, incidence, and clinical implications of people with diabetes. This analysis found that frailty is consistently associated with a range of adverse outcomes in people with diabetes, including mortality, hospital admission, disability, and lower quality of life. Similarly, a recently published observational cohort study assessing the effect of frailty on survival in patients with COVID-19 found that disease outcomes were better predicted by frailty than by either age or comorbidity. Assessing frailty in both diseases can allow physicians to make the most appropriate intervention decisions.

Equating age and frailty is short-sighted at best and actively harmful at worst. To view older people as intrinsically frail is harmful in multiple ways. First, assumptions of age-related frailty can lead to older patients being undertreated compared with younger patients. For example, treatment of older patients with cancer by chemotherapy has historically been complicated by questions of functional status, comorbidities, life expectancy, and tolerance. However, in this issue, we publish alongside our sister journal The Lancet Oncology two papers showing that women aged 70 and older with triple negative breast cancer have significantly better survival outcomes when given additional chemotherapy as part of their treatment. Second, assuming that it is only older people who are at risk of frailty risks ignoring the warning signs in younger patients. Potentially concerning data are accumulating showing that the proportions of middle-aged people who are frail are rising. At least the possibility of frailty should be included into routine assessments of middle-aged people—for example, with diabetes—for whom frailty can affect treatment outcomes.

Finally, equating age and frailty is to indulge in ageism, whereby people dismiss others on the basis of their age, irrespective of their abilities and needs. Viewing older people’s needs and abilities solely on the basis of age not only risks giving inappropriate care but can diminish their humanity and autonomy. Just as younger people might be frail, older people might not be. The time has come for both society and medicine to recognize something cliché as true: age is just a number.

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