Results: Six-month frailty progression was observed in 13 individuals (11%) with 8 (7%) transitioning from non-frail to pre-frail and 5 (4%) from pre-frail to frail. Twenty-eight individuals (24%) observed frailty regression with 17 (14%) transitioning from pre-frail to non-frail and 11 (9%) from frail to pre-frail. Decreased walking speed (38%) and low activity (80%) contributed to the transitions from non-frail to pre-frail and from pre-frail to frail, respectively. In the regression from pre-frail to non-frail increased walking speed (53%) was common, and in the regression from frail to pre-frail increased activity level (45%) and decreased self-reported exhaustion (73%) were common.

Conclusions: Change in walking speed was most common among the non-frail to/from pre-frail, whereas change in activity level was common in pre-frail to/from frail transitions. These results illustrate that 1) gait changes may occur earlier than other criteria in frailty progression, and 2) frailty is a dynamic state and should be measured regularly.

THE MULTIDIMENSIONAL INSTRUMENT TO ACCESS FRAILTY SYNDROME IN ELDERLY FROM PRIMARY CARE SETTING

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Introduction: Several authors have studied the frailty syndrome (FS) but few studies are focused on basic health care especially in Brazil. The aim of the study was to develop and validate a multidimensional instrument tracking FS in elderly patients in primary care.

Methods: A cross-sectional study enrolling 355 elderly participants of the Multidimensional Study of the Elderly in Porto Alegre from the Family Health Strategies (EMISUS). The clinical criteria for the phenotype of FS was the modified Fried (without physical activity; 0 points= no frail individuals/1 point= pre-frail/2 or more points= frail). For the development of the instrument were selected 10 dimensions (social, age, sensory, depressed mood, cognition, number of medications, ADL/IADL, balance, urinary incontinence and nutrition) categorized as present or not.

Results: Throught multiple logistic regression (Forward Wald method), considering as he dependente variable the Fried phenotype (0= no frail and 1= pre-frail/frail) and as independent variables the 10 dimensions, we found as independent predictors variables the following dimensions: undernutrition (OR= 2,66), polipharmacy (OR=1,92), dependence (OR=4,58), urinary incontinence (OR=1,88) and inbalance (OR= 3,32). We created the multidimensional instrument tracking frailty syndrome (IMSIFI) and established the cutt-off point 1 to discriminate no frail to pre-frail/frail individuals (sensibility= 0,759 and specificity= 0,563). The area under the ROC curve was 0,713. The phenotype more common was no frail (44.5%) by Fried criteria and pre-frail/frail (72.9%) by IMSIFI. Both instruments (Fried and IMSIFI) were associated with functional capacity.

Conclusion: IMSIFI is an simple, objective, and quick instrument for the context of primary care.

A MULTIFACTORIAL INTERDISCIPLINARY INTERVENTION IN PRE-FRAIL OLDER PEOPLE: RANDOMISED TRIAL

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The study aim was to determine whether an intervention could reduce pre frailty and improve mobility disability. We conducted a single centre, randomised, controlled trial among older people who were pre frail in Sydney, Australia. One group received an intervention targeting the identified characteristics of frailty, while the comparison group received the usual healthcare and support services. Outcomes were assessed by a rater masked to treatment allocation at 4 and 12 months after study entry. The primary outcomes were frailty criteria with reference to the Cardiovascular Health Study criteria, and mobility as assessed by the lower extremity continuous summary performance score (CSPS) calculated from the Short Physical Performance Battery. Secondary outcomes were also assessed. A total of 194 participants (84%) completed the study. Overall, 38% of participants were men and the mean (SD) age was 81.5 years (5.3). In the intention-to-treat analysis, the mean between group difference in frailty criteria was .062 at 12 months (95% CI -0.24 to 0.36, p=0.7). The change score on the CSPS favoured the intervention group at 4 months (0.11, 95% CI 0.004 to 0.215, p=0.042) but there was no between group difference at 12 months. There were no major differences between the groups with respect to secondary outcomes. This intervention trial for pre frail older people did not show a benefit on frailty of a multifactorial interdisciplinary intervention. The same intervention had positive effects in frail older people and the reasons for the difference are currently unclear. Trial registration: ACTRN12613000043730

FRAILTY AS PREDICTOR OF MORTALITY IN INSTITUTIONALIZED OLDER ADULTS.

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This longitudinal observational cohort study was conducted in two Spanish nursing homes. Of the 331 subjects who agreed to participate we obtained valid data of 295 subjects. Frailty was defined by the presence of three or more Fried criteria: unintentional weight loss, low energy, exhaustion, slowness, and low physical activity. Mortality during the follow-up period (2012–2015) was recorded. Demographic data, comorbidity assessed by the Charlson index and disability in basic activities of daily living using the Barthel index were recorded at baseline. All data were analyzed using the SPSS 15.0 program.The association between frailty and mortality was determined by Cox proportionalhazard analysis and logistic regression adjusted for age, sex, Barthel index, Charlson index, and body mass index (BMI). Mean age of the cohort was 83.9 (SD 6.8), with 213 women (65.1%). Mean