

Reply to M.J. Molina-Garrido et al

We would like to thank Molina-Garrido and Guillén-Ponce¹ for their comments on our article, and appreciate this opportunity to clarify some of the points they discussed.

The vulnerable elders survey-13 (VES-13) is a geriatric instrument that has been validated as a means of identifying elderly people with functional decline.² Patients are considered vulnerable if their score is 3 or higher, and an age older than 85 years is considered a criterion of vulnerability by itself. These criteria were established in a cohort of nononcologic elderly patients.

The aim of our clinical trial was to compare the accuracy of VES-13 with the Comprehensive Geriatric Assessment (CGA) in detecting disabilities in elderly patients with cancer. We made an inpatient analysis, and both scales were administered to every patient, thus reducing the possible biases arising from the type of population. Our patient series is larger than those of previously published studies, and unlike a previous study of patients with prostate cancer³ in which the comparison involved the CGA as a whole (including the evaluation of cognitive and depressive status, which are not assessed by the VES-13 items), we only compared homogeneous items (ie, we only analyzed CGA functional status scores corrected for an age older than 85 years or younger than 85 years. The conclusions of our study underline the usefulness and accuracy of VES-13 when diagnosing impaired functional status in everyday clinical practice.

The National Comprehensive Cancer Network and the International Society of Geriatric Oncology guidelines^{3a} recommend assessing elderly patients with cancer by using any form of geriatric evaluation regardless of the length of the instrument or how long it takes to complete. There is no answer to the question as to which instrument is the best. We believe that research should concentrate on identifying new screening tools for assessing the impact of geriatric impairments on oncologic outcomes (such as survival or toxicity) rather than on finding new cutoff points for classic geriatric scales, given that this should promote the wider use of geriatric assessments in oncologic clinics. Multicenter and international validations are the most appropriate methodologic means of avoiding selection biases.

The Groningen fragility index⁴ or Barber's test⁵ do not seem to be suitable, and the VES-13 itself is far from an ideal screening tool, because it evaluates only one CGA dimension and is not rapid even when self-administered. G-8 is a promising abbreviated screening instrument that has been validated by French geriatric oncology centers, and given that it will be prospectively tested in a European Organisation for Research and Treatment of Cancer clinical trial, we presume that it will soon be possible to draw more precise conclusions.

Many geriatric assessment instruments have been published, none of which can be considered the best or most accurate. Clinicians need to be aware that any modified CGA may miss some clinical information; modified versions should not completely replace the original.

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AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

The author(s) indicated no potential conflicts of interest.

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