



Geriatric Pre-operative Assessment Performance and Use Quick Reference Guide

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VALUE-BASED PRE-OPERATIVE GERIATRIC ASSESSMENT

A **comprehensive geriatric assessment (CGA)** brings function, cognition, mobility, frailty, nutrition, medications, social support, and patient priorities into one longitudinal plan.^{1,2} It is most valuable when the findings change **treatment intensity, procedural decisions, caregiver support, or the location and timing of care.**³

In the older adult (age ≥ 65) being considered for an **elective procedure, CGA is not a rubber stamp** for "clearance." The **highest-volume elective procedures in this population include: major joint arthroplasty** (knee and hip replacement, the single most common elective procedure older adults consider), **ventral and inguinal hernia repair, transcatheter aortic valve replacement, elective spine surgery** (laminectomy or fusion for stenosis), **bariatric surgery, screening or surveillance colonoscopy, and carotid endarterectomy.**^{4,5} Beyond these, **cataract and other eye surgery, elective colectomy, cholecystectomy, and lower-extremity revascularization** are also frequently performed in older adults and warrant the same functional lens.⁶⁻⁸ Across all of them, CGA is the instrument by which the primary care physician (PCP) **measures physiologic reserve and decides whether the patient can withstand** (and meaningfully recover from) **the stress of an operation.** Frailty is present in **30%-50%** of older patients presenting for major surgery and roughly **doubles the risk of morbidity, mortality, and new patient-reported disability.**⁹ Impaired mobility (e.g., Timed Up and Go > 20 seconds), recent falls, malnutrition, and cognitive impairment **independently predict** complications, prolonged length of stay, institutionalization, and death.^{3,10}



AAVBC PERSPECTIVE

*The PCP should use CGA to **protect function and independence, prevent avoidable harm, and decline or defer elective procedural clearance** when the expected burden of recovery exceeds the likely patient-centered benefit.*^{3,10}

Elective means there is time and time should be used for **conservative care first.** Before any operative pathway is planned, a genuine trial of **non-operative optimization should be the default:** treating reversible contributors to decline (depression, anemia, hypotension, hypothyroidism, B12 deficiency, adverse drug events, unstable comorbidities), **deprescribing high-risk medications,** correcting malnutrition, initiating smoking cessation, and restoring mobility through structured exercise.^{2,11} **Multimodal prehabilitation,** combining exercise, nutritional therapy, and psychological support, can improve functional capacity and lower postoperative complications, with the largest benefit in the frailest patients.¹⁰ In many cases these measures **restore enough baseline function that the procedure is no longer needed,** or is deferred until reserve is rebuilt.

The high bar for proceeding: A procedure should be planned **only after conservative care has been given a fair trial** and found insufficient, and only when the **risk-benefit balance clearly favors operation** for the outcome that matters most to the patient. The bar rises further when the **anticipated recovery requires post-acute institutional care:** if the burden of recovery risks irreversible loss of independence (prolonged rehabilitation, permanent functional decline, cognitive loss, or nursing-home placement), the rationale for the procedure over continued conservative management **must be extremely compelling and explicitly**

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