



EDITORIAL

INTRODUCING SARCOPENIA IN CLINICAL PRACTICE IN TURKEY

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Research on sarcopenia has grown in recent years in such an explosive manner that no practicing geriatrician is now unfamiliar with the term. However, this explosion is not yet translated, in most cases, into better patient care and improved outcomes, including falls, fractures, physical function, hospitalizations and mortality (1-3). In order to improve the clinical uptake of sarcopenia some organizations fostered coding of this condition in the clinical modification of the international classification of diseases (ICD-10-CM, code M62.84) (4), the newest definitions have incorporated simplified algorithms to be used in clinical practice (5,6), clinical guidelines have been developed (7,8) and research on screening tools is growing (9).

However, sarcopenia seems to be yet far for mainstream. A survey of healthcare professionals working in the national health system of the United Kingdom showed that only half of the respondents organizations identified sarcopenia, but most did not use any formal criteria to diagnose the condition and only one of the surveyed centres reported using a code for the disease (10). A similar survey in Australia and New Zealand found that less than 15% of the practitioners reported making the diagnosis of sarcopenia in their patients, and this situation was unchanged by an educational intervention (11). The situation seemed to be slightly better in the Netherlands, where 21% of the respondents of a survey reported to know how to diagnose sarcopenia and up to 82% had treated patients with the condition, but most were unaware of diagnostic tools and instruments (12). There are no similar surveys in Turkey, but there is no hint that the global picture will be different.

The prevalence of sarcopenia in Turkey has been well studied in most clinical settings. It seems to be low in the community, ranging

from 0.8% to 5.2% , depending on the instrument used to diagnose it and population characteristics (13, 14), but prevalence raises to some 14% in older inpatients (15) and can be as high as 29% to 85% in older people living in nursing homes (16,17). As sarcopenia carries a risk of impaired outcomes, including mortality, there is an evident need to detect and intervene, and Turkey seems to be better prepared than other countries to incorporate sarcopenia screening, diagnosis and treatment into mainstream practice, as has been claimed for long (18,19). This country is well represented in sarcopenia research, with several active groups in different universities (20, 21). There is plenty of information on the validity of screening tools in Turkish (22, 23), that have showed that many patients can be detected when at risk, before they develop the full condition. In fact, sarcopenia risk is also associated with unfavourable health care outcomes including dependency, malnutrition, and dysphagia (24, 25).

There is also plenty of information on cut-off points for different measures of muscle mass and muscles strength in Turkish population, based on studies in healthy young populations, that allow for a better detection and to adjust for height, weight or body mass index (24-26). A measure of sarcopenia-related quality of life (SARQOL) has also been translated and validated in Turkish (27).

Many things can be done to improve diagnosis and management of sarcopenia. Some depend on advances in research and consensus or in political decision making. For instance, a worldwide initiative to agree on a global definition of sarcopenia is ongoing (28) and updated clinical guidelines are needed. Also, sarcopenia needs to be included in the WHO International Classification of Diseases – at present it is only listed in the version named Clinical Modification and the latest version ICD-11 does not properly include sarcopenia. Implementation of ICD in Turkey is, however, still low.

Many other initiatives may be performed locally. Better education and training of healthcare professionals, routine screening in high risk settings, improved availability of diagnostic tools (bioimpedance, DXA, dynamometers) and of referral centres for sarcopenia, local clinical guidelines with well-defined clinical pathways for patients, and availability of nutritional and exercise advice that can deliver interventions that have been shown to reduce disability (29) would be steps in the right direction. Doctors who treat older patients should consider if their practices on the diagnosis and management on sarcopenia are appropriate to current knowledge or need rethinking and new training, turning their eyes back on patients (30).

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