(Partially founded with grants from Abbott Laboratoires S.A. and Nutricia Advanced Medical Nutrition).

P-356

Geriatric study in municipality of Fatih: sarcopenia and sarcopenic obesity in elderly patients according to different indexes

C. Kilic[1], G. Bahat[1], T. Fatih[1], S. Avcı[2], T. Akcan[3], Y. Medik[3], M. Karan[1].
[1]Division of Geriatric, Department of Internal Medicine, Faculty of Istanbul Medicine, Istanbul University, [2]Division of Geriatric, Department of Internal Medicine, Faculty of Cerrahpasa Medicine, Istanbul University, [3]Faculty of Istanbul Medicine, Istanbul University, Istanbul, Turkey

Introduction: In our study we evaluate patients with different definitions of sarcopenia and sarcopenic obesity and compare prevalence of cases.
Methods: We enrolled patients ages between 60 and 101. Skeletal muscle mass were measured with bioimpedance analyse (TANITA-BC532). Muscle mass assessed with Baumgartner-index. In addition; muscle mass values calculated according to Janssen, FNIHa and FNIHb definitions and low muscle mass evaluated according to national data base. Low body mass was defined as a <9.2 kg/m^2 and <7.4 kg/m^2 or <32 kg and <22 kg in male and female patients respectively. Sarcopenia defined as low-skeletal-muscle-mass-index and decreasing in muscle function according to EWGSOP's-sarcopenia definition. Our population's data <33 cm accepted as a low-calf circumference. Together with, obesity assessed with two different definition; a percentage body fat >=60TH percentile or BMI 30 kg/m^2 suggested in literature.
Results: This was a study of 204 elderly patients.(mean-age:75,4 ± 7.3). Sarcopenia and its components' prevalence are as follows: Sarcopenia (S) according to Baumgartner index: 5.3%, low muscle mass: %9.8, dynapenia: %51.5, slower walking tempo: %25.6. On the other hand; S-prevalence according to Janssen, FNIHa&FNIHb were: 29.3%,37.9% and 18%, respectively. Lower calf circumference as an indirect indicator of lower body-mass was %15,8. SO-prevalence measured with Baumgartner-BMI is 0%, with FNIHa-BMI is 24.9%, with FNIHb-BMI is 13.2%. Besides; SO-prevalence measured with Baumgartner-Zoico ile 2.1%, with Janssen-Zoico is 18.2%, with FNIHa-Zoico is %23.4, with FNIHb-Zoico is 14.7%. S-prevalence is higher among women with Janssen and FNIHa ($p < 0.001$). Similarly, SO-prevalence is higher among women with Janssen-BMI, FNIHa-BMI, FNIHb-BMI, Janssen-Zoico&FNIHa-Zoico ($p < 0.001$, $p < 0.001$, $p = 0.02$, $p < 0.001$, $p = 0.003$). According to Baumgartner-Zoico definition women don't have SO thereby it is more common in men, meaningfully ($p = 0.012$).
Key conclusions: SO-prevalence have been the lowest according to Baumgartner index. The highest S-prevalence has been detected with FNIHa description and the lowest has been detected with FNIHb. S&SO correlation with gender vary among different methods. Our results have shown that S&SO is most likely higher in women.

P-358

Hip fracture mortality and grip strength. Any relationship?

M. Neira Álvarez, E. Arias Muñana, A. Morales Fernandez, R. Bielza Galindo, J.F. Gómez Cerezo. *Hospital Infanta Sofía. Universidad Europea de Madrid. Madrid. Spain*

Objective: To identify variables related to mortality after hip fracture treatment in elders.
Methods: This prospective observational study included 127 patients who were admitted to Orthogeriatric Unit of Infanta Sofia's Hospital for hip fracture surgery from April 2013 to April 2014. The main objective was to evaluate the impact of grip strength as predictor of functional recovery. This is a mortality sub analysis.
At the time of admission were recorded: age, sex, functional status (Barthel Index), mental status (Cruz Roja Index) and hand grip strength. Follow-up was performed 3 months after discharge to assess functional status and survival.
Results: Out of 127 subjects, 103 were women and 24 were men. Mean age was 85,1 ± 0,6 years. Hand grip strength was obtained in 85 patients (76.5%), values were between 3,3 and 24,8 Kg and 81 patients (95,2%) had values below cut-point for sarcopenia.
19 patients died during the three months follow up (15%). Hand grip strength was obtained in nine of them; mean value was 10,7 ± 0,5 Kg and no relation was founded between grip strength and mortality ($p = 0,79$).
By simple linear logistic analysis sex ($p = 0,03$) and Barthel Index ($p = 0,01$) at admission shown relation to mortality. In the multiple linear regression sex was the most strongly associated with mortality ($p = 0,02$).
Conclusions: Hip fracture has a significant impact on mortality among elders.
Hand grip strength had no relationship with mortality in hip fracture patients.
Factors related to mortality were sex and previous functional status.
The authors have no financial support from commercial parties.

P-359

Comparison of frailty screening instruments in the emergency department

M. Costello[1,2], L. Spooner[3], C. Small[1], A. Flannery[1], L. O'Reilly[3], L. Heffernan[3], E. Mannion[4], O. Sheil[4], S. Bruen[4], P. Burke[4], M. McMahon[4], N. Kyne[4], W. Molloy[5], A. Maughan[6], A. Joyce[6], H. Hanrahan[2], G. Stallard[3], J. O'Donnell[3], R. O'Caoimh[1,2]. *[1]Department of Geriatric Medicine, University Hospital Galway, Newcastle rd, Galway City, [2]Health Research Board Clinical Research Facility Galway, National University of Ireland, Galway, Geata an Eolais, University Road, Galway, [3]Department of Emergency Medicine, University Hospital Galway, Newcastle road, [4]Frail Elderly Assessment Team, University Hospital Galway, Newcastle road, Galway City, Ireland, [5]Centre for Gerontology and Rehabilitation, University College Cork, St Finbarrs Hospital, Douglas Rd, Cork City, Ireland, [6]PCCC, Shantalla Health Centre, Costello road, Galway City, Ireland*

Introduction: Although several frailty screens may be suitable for use in the Emergency Department, it is not known which is most accurate and practical to deploy in clinical practice.
Methods: We compared the accuracy of three validated, short, frailty and risk-prediction screening instruments to predict frailty at triage in a university hospital ED. Consecutive older adults aged >70 years self-administered the PRISMA-7 and the ISAR on arrival to ED triage. Trained nurses independently scored the Clinical Frailty Scale (CFS) blind to the diagnosis and the results of the self-administered screening. A consultant physician using a battery of frailty instruments including the FRAIL Scale independently determined each patient's frailty status.
Results: In total, 210 patients were screened, median age (interquartile range +/−) 79 (+/−9) years of which 47% were male. Based upon the FRAIL scale classification 28% of patients were classified as robust, 40% pre-frail and 32% as frail. The median ISAR score was 3 (+/−3), CFS 4 (+/−2) and PRISMA-7 3 (+/−2). Inter-rater reliability of the CFS was strong, $r = 0.78$. The most accurate instrument for separating frail from non-frail (including pre-frail) was the PRISMA-7,(AUC 0.88; 95% CI:0.83–0.93) followed by the CFS (AUC 0.83; 0.77–0.88) and the ISAR (AUC 0.78; 0.71–0.84). The PRISMA-7 was statistically significantly more accurate than the ISAR ($p = 0.008$), but not the CFS ($z = 1.4$, $p = 0.15$). The PRISMA-7 was also the most accurate at differentiating pre-frail from frail (AUC of 0.71; 0.62–0.79).
Conclusion: Screening for frailty in the ED with a selection of short screening instruments is reliable and accurate The PRISMA-7 was the most accurate, consistent with findings in primary care.

P-360

Point prevalence of frailty in the emergency department

C. Small[1], L. Spooner[2], M. Costello[3], C. Small[1], A. Flannery[1], L. O'Reilly[2], L. Heffernan[2], E. Mannion[4], O. Sheil[4], S. Bruen[4], P. Burke[4], M. McMahon[4], N. Kyne[4], W. Molloy[5], A. Maughan[6], A. Joyce[6], H. Hanrahan[2], G. Stallard[2], J. O'Donnell[2], R. O'Caoimh[1,3]. *[1]Department of Geriatric Medicine, University Hospital Galway, Newcastle rd,*