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The role of geriatricians in the emergency department

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Dear Editor,

We read with great interest the Educational Paper by Colantoni and colleagues recently published in *Emergency Care Journal*.[1] We particularly appreciated the attention paid to the potential role of Geriatric Emergency Departments —an entity not yet well defined in Italy. The increasing number of older patients with multimorbidity and/or frailty attending EDs represents an emerging challenge, and the training of Emergency Physicians (EPs) alone may not always be sufficient to address their complex needs.

To this purpose, a project was conducted at the Emergency Department of Santa Croce e Carle Hospital in Cuneo, northwestern Italy, to integrate a geriatrician into the ED team during selected shifts. We conducted a retrospective analysis of 74,152 patients presenting to our ED from January 1, 2022, to November 30, 2023, excluding paediatric, obstetric, gynaecologic, orthopaedic, and ophthalmologic cases. Performance indicators were compared between patients managed by EPs and those managed by geriatricians, both in the overall population and among patients aged ≥80 years.

A total of 1,224 patients were managed by geriatricians and 72,928 by EPs. Patients seen by geriatricians were older (median age 67 [IQR 48–80] years) compared with those seen by EPs (60 [41–76] years; $p<0.001$). Median treatment time was 2.3 [1.1–4.1] hours for

EPs versus 3.1 [1.8–5.1] hours for geriatricians (p<0.001). Among patients aged ≥80 years, treatment times were similar (2.9 [1.7–4.8] vs. 3.3 [2.1–5.2] hours; p=0.23). Overall admission rates were comparable (25.0% *vs*. 24.8%; p=0.84). However, among patients aged ≥80 years, geriatricians admitted fewer patients than EPs (39.3% vs. 44.9%; p=0.04), particularly among high-priority triage cases (54% *vs*. 63%; p=0.05). In this age group, geriatricians requested fewer abdominal CT scans (0.3% *vs*. 3.2%; p=0.003), while no significant differences were observed for laboratory tests (high-sensitivity troponin I, procalcitonin) or other imaging modalities (non-contrast head CT, contrast chest CT). This finding may reflect a more tailored diagnostic approach in frail older adults, in whom the appropriateness of imaging should balance expected diagnostic benefit with the risk of overtesting, incidental findings, contrast-related complications, and prolonged ED length of stay. The integration of geriatric expertise may therefore contribute to a more appropriate use of diagnostic resources in the ED setting.

Previous reports have shown that GEDs are associated with shorter ED length of stay and similar discharge rates.[2,3] In our experience, although geriatricians' cases had slightly longer treatment times overall, this difference disappeared in the oldest patients, while hospital admissions were fewer—especially in the most complex cases.

As population aging and chronic disease burden continue to challenge emergency medicine, our findings support the growing evidence that geriatricians can play a pivotal role in addressing frailty, multimorbidity, and cognitive disorders in the ED setting.[4] Geriatricians can assist EPs in implementing Comprehensive Geriatric Assessment within the ED – supporting frailty-adjusted risk stratification, delirium prevention, medication review, and end-of-life care – [5] and in activating out-of-hospital multidisciplinary care pathways.

References

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