

chronic disease, accommodating for cognitive and functional decline and collaborating with families and other informal caregivers, the goal being a reasonable preservation of an individual's independence balanced against their care and safety needs. Teams of health care workers must recognize the unique features of each case and bring flexibility and a degree of realistic optimism to the job.

A potential danger in the use of tools (such as the Canadian Study of Health and Aging Clinical Frailty Scale) is that a patient might be assigned to a category from which he or she cannot escape: although the health of an elderly person can improve, it is potentially time-consuming and inconvenient for a health care system to reassess him or her. There is a significant risk that expediency might override fairness.

Perhaps efforts would be best focused on developing collaborative and effective health care delivery systems for elderly people in need that accentuate realistic optimism and flexibility. This might be of more use than the ongoing efforts to define a condition that in most instances is self-evident.

Doug Duke
Family Physician
Edmonton, Alta.

REFERENCE

1. Rockwood K, Song X, MacKnight C, et al. A global clinical measure of fitness and frailty in elderly people. *CMAJ* 2005;173(5):489-95.

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[The authors respond:]

In his comments on our article,¹ Doug Duke usefully reminds us that the care of elderly people is complex and commonly requires a multidisciplinary approach. He cautions that, if we use tools to assign patients to a frailty category, "expediency might override fairness." This is, of course, a concern. However, older people who are reasonably fit derive little additional benefit from complex, multidisciplinary care compared with usual care, whereas elderly people who are frail benefit

greatly.²⁻⁴ A pragmatic, nonarbitrary way is thus needed to classify relative degrees of fitness and frailty. In addition to being useful for research purposes, the scale we described aims to meet this need.

Kenneth Rockwood
Chris MacKnight
Division of Geriatric Medicine
Dalhousie University
Halifax, NS
Howard Bergman
Division of Geriatric Medicine
McGill University
Montréal, Que.

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2. Maly RC, Hirsch SH, Reuben DH. The performance of simple instruments in detecting geriatric conditions and selecting community-dwelling older people for geriatric assessment. *Age Ageing* 1997;26:223-31.
3. Rockwood K, Stadnyk K, Carver D, et al. A clinimetric evaluation of specialized geriatric care for rural dwelling, frail older people. *J Am Geriatr Soc* 2000;48:1080-5.
4. Gill TM, Baker DI, Gottschalk M, et al. A program to prevent functional decline in physically frail, elderly persons who live at home. *N Engl J Med* 2002;347:1068-74.

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Corrections

An assay was incorrectly listed in Table 1 of a recent review article on troponin.¹ The fourth assay from the bottom of the table should have read RAMP, Response Biomedical. The corrected table appears below (Table 1).

REFERENCE

1. Babuin L, Jaffe AS. Troponin: the biomarker of choice for the detection of cardiac injury. *CMAJ* 2005;173(10):1191-202.

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The estimated capital costs in the US over 5 years to achieve a National Health Network were determined by an expert panel to be US\$156 billion and not US\$400 billion as reported in a recent lead editorial.^{1,2} We thank Stephen Chris, from Toronto, for bringing this matter to our attention.

REFERENCES

1. Have paper records passed their expiry date? [editorial]. *CMAJ* 2005;173(7):725.
2. Les dossiers papiers sont-ils périmés? [éditorial]. *JAMC* 2005;173(7):727.

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Table 1: Cut-off values of cardiac troponin assays

Assay	LLD	99th percentile	10% CV*	ROC curve
ARCH STAT Troponin-I, Abbott Diagnostics	0.009	0.012	0.032	0.3
AxSYM Troponin-I ADV, Abbott Diagnostics	0.02	0.04	0.16	0.4
i-STAT,† Abbott Laboratories	0.02	0.08 (WB)	0.1	ND
Centaur, Bayer Diagnostics	0.02	0.1	0.35	1.0
Access AccuTnI Troponin I, Beckman Coulter	0.01	0.04	0.06	0.5
Triage Cardiac Panel,† Biosite	0.19	< 0.19	0.5	0.4
Dimension RxL, Dade Behring	0.04	0.07	0.14	0.6-1.5
Stratus CS,† Dade Behring	0.03	0.07	0.06	0.6-1.5
Immolute, Diagnostic Products Corporation	0.1	0.2	0.6	1.0
Vitros, Ortho-Clinical Diagnostics	0.02	0.08	0.12	0.4
RAMP,† Response Biomedical	0.03	< 0.03 (WB)	0.21	ND
Elecsys, Roche Diagnostics	0.01	< 0.01	0.03	0.1
Reader,† Roche Diagnostics	0.05	< 0.05 (WB)	ND	0.1
Tosoh AIA, Global Medical Instrumentation Inc.	0.06	< 0.06	0.06	0.31-0.64

Note: LLD = lower limit of detection, CV = coefficient of variation, ROC = receiver operating characteristic, ND = not determined, WB = whole blood. *Per manufacturer. †Point-of-care assay FDA-cleared as high-sensitivity assay 2004 (CS). Source: Apple et al.⁵⁷