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Review

Adult Failure to Thrive: A Nonspecific Diagnosis with High Stakes for Older Adults

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A B S T R A C T

Background: "Failure to thrive" (FTT) is a familiar phrase in the care of older adults, but it is also one of the least precise labels in clinical medicine. In adults, it is commonly used to describe weight loss, poor appetite, inadequate nutrition, inactivity, and functional decline, yet it often functions more as shorthand for uncertainty than as a diagnosis.

Objective: To review current evidence on adult FTT, examine its relationship to frailty and functional decline, and propose a practical biopsychosocial framework for evaluating older adults labeled as failing to thrive, with emphasis on emergency department (ED) and inpatient care.

Methods: A narrative review of clinical studies, reviews, and guidelines on adult or geriatric FTT and related constructs in adults aged 65 years and older was conducted using PubMed, MEDLINE, and Embase. Additional sources were identified through citation tracking and geriatric emergency medicine resources.

Results: Adult FTT is best understood as a nonspecific manifestation of underlying medical, psychological, and social pathology rather than a stand-alone disease. Patients given this label often have acute illness, substantial healthcare utilization, and poor outcomes. Frailty is increasingly recognized as a more measurable syndrome of diminished physiologic reserve, whereas FTT remains descriptive and imprecise. Contemporary guidance favors replacing vague labels with precise descriptions of symptoms, frailty, and underlying disease, while conducting structured assessments of cognition, mood, nutrition, mobility, and social supports.

Conclusions: Adult FTT should be viewed as a clinical warning sign, not a final diagnosis. A frailty-informed, biopsychosocial approach may improve diagnostic accuracy, prognostication, and alignment of care with patient goals.

Keywords: adult failure to thrive; frailty; functional decline; biopsychosocial framework; narrative review; healthcare utilization

Introduction

Few chart labels are as familiar-and as unsatisfying-as "failure to thrive." In pediatrics, the phrase directs clinicians to growth curves, nutrition, and clear evaluation pathways. In adult medicine, by contrast, it often appears when an older patient has weight loss, poor intake, weakness, slowing, or functional decline, but no one has yet identified what is actually wrong. The result is a term that feels clinically recognizable yet remains diagnostically vague.

That vagueness matters. Older adults given an FTT label often have serious underlying disease, including infection, malignancy, cardiovascular illness, medication toxicity, depression, delirium, or progressive frailty[1]. In practice, the label can flatten a complex presentation into a single phrase and unintentionally suggest that decline is expected, unavoidable, or mainly social[2]. This label can encourage premature closure at the very moment when older adults most need careful diagnostic thinking.

This is why adult FTT deserves a fresh look. It offers an important case study in how language shapes clinical reasoning: the words entered into the chart influence what diagnoses are pursued, how urgency is perceived, and how care plans are framed. This review examines how adult FTT has been defined, why it overlaps with frailty, what outcomes are associated with the label, and how clinicians can replace it with a more useful biopsychosocial framework for bedside assessment.

Methods

This narrative review examined the literature on adult and geriatric FTT, with particular attention to ED and inpatient use. The review addressed three questions: how adult FTT is defined and used in clinical practice, how it relates to frailty and other geriatric syndromes, and what frameworks have been proposed for evaluating older adults labeled as failing to thrive.

Literature search

PubMed, MEDLINE, and Embase were searched for English-language articles from database inception through [insert month and year] using combinations of the terms "adult failure to thrive," "geriatric failure to thrive," "frailty," "functional decline," "nonspecific complaints," and "emergency department." Additional sources were identified through reference review, citation tracking, and review of selected gray literature relevant to geriatric emergency care[3].

Study selection and synthesis

Because this was a narrative review, formal systematic inclusion and exclusion procedures were not applied. Priority was given to peer-reviewed clinical studies, reviews, and guidelines addressing adult or geriatric FTT; its outcomes; its overlap with frailty and functional decline; or approaches to evaluating older adults with nonspecific decline in ED or hospital settings. Articles focused exclusively on pediatric FTT or on unrelated uses of the term were excluded. Findings were synthesized narratively because definitions, populations, and settings were heterogeneous[4].

Historical and conceptual background of adult failure to thrive

The term "failure to thrive" originated in pediatrics, where it describes inadequate growth and undernutrition, largely identified through serial anthropometric measurements. It was later adopted in geriatric medicine and applied to older adults with progressive loss of independence, chronic illness, and functional decline[5]. Unlike in pediatrics, adult FTT never acquired standardized criteria. Instead, it evolved into a broad label for decline[6].

Traditional adult definitions describe FTT as a multifactorial syndrome characterized by unintentional weight loss, decreased appetite, poor nutrition, inactivity, and worsening physical function[5,6]. Other descriptions include depression, cognitive impairment, dehydration, and social vulnerability, which helps explain why the term feels clinically intuitive yet remains unstable. It gestures toward a real syndrome of multidimensional decline, but it does not clearly distinguish frailty from disability, depression from dementia, or chronic vulnerability from acute illness[7].

This ambiguity is the key conceptual problem. Adult FTT often describes the visible result of decline without identifying its cause. That distinction is clinically important; a patient is not sick because they "have FTT"; rather, they appear to be failing because of a combination of medical illness, cognitive change, mood disorder, malnutrition, frailty, and social stress[8].

Adult failure to thrive as a nonspecific clinical construct

In daily practice, adult FTT often serves as a placeholder for uncertainty. It is commonly applied to older adults with weakness, poor oral intake, weight loss, fatigue, confusion, falls, or generalized decline when no single explanation is immediately apparent. In the ED or on hospital admission, it may quietly suggest that the patient is clearly unwell yet does not fit neatly into an organ-system diagnosis[8-10].

The problem is that such shorthand can blur rather than clarify. Because FTT may bundle together frailty, malnutrition, depression, cognitive impairment, caregiver strain, and occult acute illness, it often tells the next clinician very little about what is driving the presentation. Worse, it may lower the perceived urgency of the case by suggesting a chronic, expected, or primarily social process. In older adults, whose serious illness often presents atypically, that is a setup for missed pathology[9,10].

Retrospective data challenge the notion that adult FTT is simply a "social admission." In one cohort of older adults admitted with FTT, patients frequently underwent extensive diagnostic testing and treatment, and investigators concluded that acute illness, rather than social factors, was the primary reason for hospitalization[6,11]. A more useful way to think about the label, then, is as a warning sign that the patient's story has not yet been translated into a precise clinical problem list.

Adult failure to thrive and the frailty phenotype (Table 1)

Adult FTT and frailty overlap so often that they are sometimes used interchangeably, but they are not the same. FTT is a broad descriptive label for multidimensional decline. Frailty, by contrast, is a defined geriatric syndrome characterized by diminished physiologic reserve and heightened vulnerability to stressors[12].

The frailty phenotype, most associated with Fried and colleagues, includes five measurable criteria: unintentional weight loss, exhaustion, weakness, slow walking speed, and

low physical activity. Frailty is present when three or more criteria are met. That structure matters. It gives clinicians a reproducible way to identify vulnerability, estimate prognosis, and communicate risk[13].

FTT lacks precision. It may refer to weight loss, poor intake, depression, functional dependence, cognitive decline, or social deterioration, depending on who uses the term. Many patients labeled with FTT would likely meet at least some frailty criteria, but the reverse is not always true[13-15]. Frailty offers an important lesson in clinical language: a good construct does not just sound right-it organizes observation, sharpens risk assessment, and changes what clinicians do next.

Table 1: Comparison of adult failure to thrive and the frailty phenotype[12-15].

Feature	Adult FTT	Frailty phenotype
Core concept	Broad descriptive syndrome of decline.	Defined geriatric syndrome of reduced physiologic reserve.
Typical components	Weight loss, poor appetite, malnutrition, inactivity, functional/cognitive/social decline.	Weight loss, exhaustion, weakness, slowness, low physical activity.
Standardized criteria	No universally accepted criteria.	Yes; 5 measurable criteria, with frailty at 3 or more.
Main limitation	Vague, heterogeneous, may obscure diagnosis.	Captures physical frailty better than broader psychosocial decline.
Main value	Signals multidimensional vulnerability.	Supports structured risk stratification and prognosis.

Biopsychosocial contributors to adult failure to thrive (Table 2)

One reason adult FTT persists is that it reflects something real: older adults rarely decline in a single domain. The literature consistently describes FTT as a multifactorial condition shaped by medical illness, psychological and cognitive disorders, nutritional compromise, functional impairment, and social vulnerability[6].

Medical contributors include chronic organ disease, malignancy, endocrine disorders, dehydration, dysphagia, poor dentition, and medication effects such as anorexia or sedation from polypharmacy[11,16]. Psychological and cognitive contributors include depression, apathy, dementia, and delirium, all of which may worsen intake, activity, and self-care[16]. Social contributors such as isolation, caregiver strain, financial hardship, sensory impairment, and inadequate home support may further destabilize an already vulnerable patient.

Adult FTT is therefore not a diagnosis to memorize but a reminder to think across domains. Several authors repeatedly point to four high-yield areas-physical function, nutrition, mood, and cognition-as the domains where older adults with decline most often present. That multidomain mindset is far more useful at the bedside than the label itself[11,16].

Table 2: Biopsychosocial Contributors to Adult "Failure to Thrive" in Older Adults[6,11,16].

Domain	Common contributors	Typical bedside clues	Example interventions
Medical	Heart failure, COPD, CKD, malignancy, endocrine disease, medication toxicity	Dyspnea, edema, orthostasis, new pain, polypharmacy	Treat acute illness, deprescribe, optimize chronic disease
Psychological / Cognitive	Depression, dementia, delirium, anxiety, apathy	Low mood, anhedonia, inattention, fluctuating cognition	Antidepressant or psychotherapy, delirium management, caregiver education
Functional / Nutritional	Sarcopenia, deconditioning, dysphagia, poor dentition, malnutrition	Weight loss, slow gait, falls, difficulty with ADLs, chewing/swallowing problems	PT/OT, swallow evaluation, dietitian consult, adaptive equipment
Social / Environmental	Isolation, caregiver burnout, food insecurity, unsafe home	Missed visits, empty fridge, overwhelmed caregiver, unsafe housing	Social work, home services, caregiver support, community resources

Clinical outcomes and consequences of diagnostic labeling

Adult FTT is associated with prolonged hospitalization, meaningful mortality, and substantial healthcare utilization, so it should not be mistaken for a low-acuity diagnosis. In one retrospective study, older adults hospitalized with FTT had an average length of stay of 12 days7. A large administrative analysis of 6,733 patients with adult FTT found a 3.16% mortality rate, a mean hospital stay of 7.34 days, ICU use in a subset of patients, and substantial direct costs[17].

These outcomes matter for two reasons. First, they reinforce that patients labeled with FTT are often medically ill, not merely awaiting placement. Second, they suggest that the label itself may shape care in unhelpful ways[6]. Older adults admitted through the ED with FTT or similar nonspecific diagnoses have experienced longer delays to admission than those admitted with more specific acute diagnoses[7]. In other words, the term may function not only as a marker of vulnerability but also as a contributor to diagnostic delay. Chart language has real consequences for patient trajectories: a vague label does not merely describe uncertainty; it can perpetuate it.

Emergency department and inpatient implications

The risks of the FTT label become most apparent in the ED, where older adults frequently present with weakness, fatigue, confusion, poor intake, or the deceptively simple statement that they are "not doing well." Geriatric emergency medicine guidance argues that FTT should not reassure clinicians; if anything, it should heighten suspicion that a serious problem has not yet been identified. Infection, stroke, heart failure, medication toxicity, electrolyte disturbance, delirium, and other dangerous conditions may all present this way[10,11,16,18].

A high-value ED approach begins with addressing immediate threats and maintaining a clean differential. Clinicians should actively assess for abnormal vital signs, hypoglycemia, hypoxia, dehydration, delirium, and acute neurologic changes, while clarifying the time course of decline, medication changes, falls, baseline cognition and mobility, and available support[19,20]. Documentation should then shift from FTT to explicit problem-based language: acute functional decline, anorexia and weakness, recurrent falls, poor oral intake, delirium, or frailty.

Frailty assessment can add prognostic value when no single diagnosis immediately explains the presentation. Tools such as the Clinical Frailty Scale may help identify patients at risk for decompensation, prolonged stay, and unsafe discharge, independent of age. In the hospital, that information can support earlier involvement of geriatrics, therapy services, nutrition, case management, and palliative care[14,15,21].

The practical point is simple: patients should not be admitted solely because they "have FTT." They should be admitted because they have unresolved acute illness, delirium, inability to maintain intake, severe functional decline, or unsafe living circumstances[21]. That shift in framing is subtle, but it changes both diagnostic reasoning and disposition planning.

A practical framework for evaluation (Table 3)

If adult FTT is not a diagnosis, what should replace it? The most useful answer is not another label but a framework. Comprehensive geriatric assessment (CGA) provides that structure by integrating medical illness, medications, cognition, mood, function, nutrition, and social context into a coordinated care plan[19,20,22].

At the bedside, this framework can be distilled into five practical questions[19,22]. First, what acute medical condition might be present-such as infection, metabolic disturbance, dehydration, medication toxicity, delirium, or cardiovascular disease? Second, what cognitive or psychiatric factors are contributing, including dementia, delirium, depression, or apathy? Third, what is the patient's functional and nutritional trajectory: recent weight loss, swallowing difficulty, falls, dependence in activities of daily living, or loss of mobility[23]? Fourth, what social factors limit safe care, such as caregiver strain, isolation, transportation barriers, food insecurity, or unsafe housing? Fifth, how should these findings be integrated into a multidomain problem list and disposition plan?

When the presenting complaint is vague, the response should not be vaguer terminology but a more disciplined clinical structure-one that extends well beyond geriatric medicine.

Table 3: A Practical Bedside Framework for Older Adults Labeled as "Failure to Thrive"[19,20,22].

Domain	Key questions	High-yield tools/examples
Acute medical illness	Could this be infection, cardiac, metabolic, medication-related, or other time-sensitive pathology?	Vitals, basic labs, ECG, targeted imaging, med review
Cognition and mood	Is there delirium, dementia, depression, or anxiety contributing to decline?	CAM or 4AT, brief cognitive screen, PHQ-2/9, collateral history
Function and nutrition	How have ADLs, IADLs, gait, and weight changed over the last weeks to months?	ADL/IADL checklist, gait assessment, recent weights, swallow screening
Social supports	Who helps at home, and is that support adequate and sustainable?	Social work screen, caregiver interview, home safety questions
Disposition and goals	What level of care and goals best fit prognosis and patient preferences?	Clinical Frailty Scale, goals-of-care conversation, PT/OT and case management input

Implications for terminology, documentation, and care planning

The growing literature on adult FTT makes a consistent point: the term is less useful as a diagnosis than as a sign that further diagnostic work is needed. Because it is vague, it can obscure active medical problems, reinforce age-related bias, and imply that decline is inevitable rather than potentially reversible[24-25]. Clinicians should therefore replace FTT with more precise language, such as acute functional decline, poor oral intake with weight loss, delirium superimposed on dementia, or frailty with recurrent falls[1].

That shift improves more than style. A chart listing only FTT leaves it unclear whether the central issue is sepsis, malnutrition, depression, cognitive impairment, medication toxicity, social isolation, or progressive frailty. By contrast, multidomain documentation supports clearer handoffs, more targeted consultation, and stronger care planning[22].

Terminology also matters in goals-of-care discussions. More specific language helps clinicians distinguish patients with potentially reversible decline from those whose presentation reflects advanced frailty and limited reserve[25]. This distinction is especially important in hospice and palliative care settings, where adult FTT alone is not sufficient as a primary diagnosis and must instead be linked to an underlying advanced illness and prognosis.

Sample ED presentation

A useful geriatric presentation should include illness severity, the suspected acute process, baseline versus current cognition and mobility, key workup findings, remaining concerns, and the specific reason discharge is unsafe. Rather than saying, "I have an 84-year-old here for failure to thrive," start with the actual syndrome: "I have an 84-year-old frail woman with two weeks of worsening oral intake, weakness, and falls, now with acute confusion and inability to transfer safely at home." Then define the baseline, current deficits, likely diagnosis, dangerous alternatives, and disposition needs. That approach promotes clearer thinking and prevents the label from doing the thinking for you[25-27].

Future Directions and Research Gaps

Despite decades of use, adult FTT remains poorly defined, and that ambiguity continues to limit both research and practice[6]. A major priority is the development of clearer terminology that distinguishes adult FTT from frailty, disability, malnutrition, depression, and nonspecific decline. Without that clarity, studies of prevalence, outcomes, and resource use will remain difficult to compare[25-27].

Prospective outcomes research is also needed. Existing studies suggest that patients labeled with FTT often experience acute illness, delayed care, prolonged hospitalization, and significant mortality, but the evidence base remains sparse and heavily retrospective[25]. Improved phenotyping of older adults with nonspecific complaints in the ED may clarify whether adult FTT should be retired entirely or replaced with more structured syndromic categories[27].

Future work should also examine whether frailty-based approaches outperform traditional FTT labeling in acute care[23]. Studies comparing frailty screening, symptom-based documentation, and FTT labeling could clarify effects on clinician behavior, consultation patterns, disposition accuracy, and patient-centered outcomes. Qualitative research should also explore how the term shapes communication, triage, and perceptions of reversibility or prognosis.

Limitations

This review has limitations inherent to its narrative design. Although the search of PubMed, MEDLINE, and Embase was structured and included citation tracking, it was not a formal systematic review, and relevant studies indexed elsewhere may have been missed. Article selection and interpretation relied on author judgment, introducing potential selection and emphasis bias. Included studies were heterogeneous in their definitions of adult FTT, study designs, and settings, precluding quantitative synthesis. In addition, evidence specific to adult FTT in ED and acute hospital contexts remains limited, so some recommendations draw on related frailty and nonspecific complaint literature[5,9].

Discussion

This review highlights a central tension in the care of older adults labeled with FTT: the term remains familiar, but it is conceptually imprecise and often unhelpful as a diagnostic endpoint. Adult FTT describes a recognizable pattern of multidimensional decline, yet the literature suggests that this pattern usually reflects interacting medical, psychological, functional, and social vulnerabilities rather than a discrete disease[1,2].

The main implication is that adult FTT should be reframed from a diagnosis to a trigger for broader assessment. Older adults assigned this label frequently have acute illness, significant frailty, or both, and they experience substantial morbidity, mortality, and healthcare utilization[27]. Frailty offers a more measurable and clinically actionable framework for risk stratification and prognostication, but it should complement-not replace-a careful search for reversible pathology. The points in **(Table 4)** highlight how small shifts in language and framing can change bedside care, shape diagnostic reasoning on rounds, and improve the handoffs patients experience.

Table 4: Key Take-Home Points for the Older Adult with "Failure to Thrive"[5,6,11,12,28].

Principle	Why it matters	Practical application
FTT is a signal, not a diagnosis	The label is nonspecific and can obscure the true drivers of decline.	Treat "FTT" as a prompt to look for medical, cognitive, mood, functional, and social causes.
Frailty helps, but does not replace evaluation	Frailty can sharpen risk assessment, but it does not explain acute change by itself.	Use frailty to frame risk while still evaluating for reversible illness.
Name the actual problems	Vague labels weaken presentations and handoffs.	Present specific concerns such as delirium, poor intake, recurrent falls, or acute functional decline instead of saying "FTT."
Think in domains	Older adults often decline for multiple overlapping reasons rather than one isolated diagnosis.	Systematically assess medical illness, mood/cognition, function/nutrition, and social context.
Get collateral early	Baseline function and recent decline are often hard to define from the patient alone.	Call family, caregivers, EMS, or facility staff early to clarify trajectory and safety concerns.
Disposition requires more than a medical screen	A patient may be medically stable but still unsafe for discharge because of frailty or inadequate supports.	Assess function, home safety, and caregiver capacity before deciding where the patient should go.
Change your language in handoffs	Language shapes clinical reasoning and team understanding.	Do not sign out "FTT admit"; state the acute illness, geriatric syndromes, and why discharge is or is not safe.

Not all authors agree that adult FTT should be abandoned outright. Some clinicians continue to defend the label as a pragmatic shorthand that flags a genuinely vulnerable patient for closer nursing, social work, and multidisciplinary attention, particularly in settings where formal geriatric assessment is not readily available[6,21]. This tension is instructive: the label may retain triage value even as it fails as a diagnostic endpoint. Streiter and Tulebaev similarly argue that FTT should not be equated with a "social admission," but they stop short of recommending its removal from clinical vocabulary, instead calling for more disciplined use alongside a thorough medical workup[21]. Our review extends this position by proposing a specific bedside framework and a problem-based documentation language that operationalizes what "more disciplined use" should look like in the ED and on the inpatient wards.

The practice-level implications of this shift are substantial. Replacing FTT with problem-based language, such as acute functional decline, delirium superimposed on dementia, or frailty with recurrent falls, changes not only documentation but also the clinical actions that follow, including which consultants are engaged, how urgently diagnostic testing is pursued, and how disposition and goals-of-care conversations are framed[19,22,25]. Prior work has shown that patients admitted with nonspecific labels like FTT experience longer delays to admission than those with more specific acute diagnoses, suggesting that terminology itself can function as a system-level bottleneck rather than a neutral descriptor[7]. Systematically incorporating frailty screening tools, such as the Clinical Frailty Scale, into ED workflows may help counteract this effect by giving clinicians a structured, reproducible alternative to the FTT label[14,15,23].

These implications should be considered alongside the limitations of the underlying evidence base. Because the literature on adult FTT is heterogeneous, largely retrospective, and drawn from varied clinical settings, causal claims about how the label itself affects outcomes cannot be firmly established[5,9,25]. It remains possible that FTT is applied preferentially to patients who are already sicker or more socially vulnerable, which would confound any observed association between the label and adverse outcomes. Future prospective and qualitative work, as outlined above, is needed to determine whether deliberately retiring the term-rather than simply improving how clinicians think about the patients it currently captures-yields measurable improvements in diagnostic accuracy, time to appropriate consultation, or disposition safety[26,27].

Conclusion

Adult failure to thrive remains a familiar yet imprecise term in the care of older adults. The literature suggests that it is best understood as a descriptive syndrome of multidimensional vulnerability rather than a discrete diagnosis, and that its continued use may obscure acute illness and complicate care planning.

A better approach is to move beyond the label and evaluate older adults using a frailty-informed, biopsychosocial framework that addresses medical illness, cognition, mood, nutrition, function, medications, and social supports. For clinicians alike, the core challenge is not deciding whether a patient "has FTT," but rather identifying the interacting factors driving decline and responding with care that is precise, goal-concordant, and clinically honest.

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