SARC-F: a symptom score to predict persons with sarcopenia at risk for poor functional outcomes

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Background  A brief, inexpensive screening test for sarcopenia would be helpful for clinicians and their patients. To screen for persons with sarcopenia, we developed a simple five-item questionnaire (SARC-F) based on cardinal features or consequences of sarcopenia.

Methods  We investigated the utility of SARC-F in the African American Health (AAH) study, Baltimore Longitudinal Study of Aging (BLSA), and National Health and Nutrition Examination Survey (NHANES). Internal consistency reliability for SARC-F was determined using Cronbach’s alpha. We evaluated SARC-F factorial validity using principal components analysis and criterion validity by examining its association with exam-based indicators of sarcopenia. Construct validity was examined using cross-sectional and longitudinal differences among those with high (≥4) vs. low (<4) SARC-F scores for mortality and health outcomes.

Results  SARC-F exhibited good internal consistency reliability and factorial, criterion, and construct validity. AAH participants with SARC-F scores ≥4 had more Instrumental Activity of Daily Living (IADL) deficits, slower chair stand times, lower grip strength, lower short physical performance battery scores, and a higher likelihood of having a gait speed of <0.8 m/s. SARC-F scores ≥4 in AAH also were associated with 6 year IADL deficits, slower chair stand times, lower short physical performance battery scores, having a gait speed of <0.8 m/s, being hospitalized recently, and mortality. SARC-F scores ≥4 in the BLSA cohort were associated with having more IADL deficits and lower grip strength (both hands) in cross-sectional comparisons and with IADL deficits, lower grip strength (both hands), and mortality at follow-up. NHANES participants with SARC-F scores ≥4 had slower 20 ft walk times, had lower peak force knee extensor strength, and were more likely to have been hospitalized recently in cross-sectional analyses.

Conclusions  The SARC-F proved internally consistent and valid for detecting persons at risk for adverse outcomes from sarcopenia in AAH, BLSA, and NHANES.

Keywords  Sarcopenia; Screening; Mobility; Function

Introduction

Sarcopenia was originally defined as age-related loss of muscle mass.1,2 Recently, a number of definitions of sarcopenia have been suggested that include a functional measure (e.g. limited mobility) together with appendicular lean mass corrected for height.3–5 Others have argued that muscle strength or power is a more appropriate addition to loss of muscle mass or that a new term dynapenia (poverty of muscle strength/power) should be used separately from sarcopenia, which then would be reserved solely for poverty of muscle mass.6–8 Regardless of definitional refinements, sarcopenia measured in several different ways has been associated with multiple adverse outcomes.9–5 No easily applied sarcopenia measure currently exists for use in usual clinical settings.
In the osteoporosis field, it has been demonstrated that a simple questionnaire (FRAX) can predict persons with elevated risk of osteoporotic fracture without the requirement of measuring bone mineral density (BMD).9,10 As loss of muscle mass, unlike loss of bone, has a clear clinical symptom, that is, weakness, it should be possible to create a simple symptom score that will predict both sarcopenia and poor outcomes in persons with sarcopenia.

Our group has been conducting a panel study of community-dwelling, late middle-aged African Americans who were 49–65 years of age at cohort initiation in 2000–01, have high levels of disability,11,12 and are known collectively as the African American Health (AAH) cohort. Previously, we have shown in this cohort that the increase in disability over 9 years can be predicted in those with limited mobility and low lean mass,13 but this measure requires in-person and laboratory assessments. The Baltimore Longitudinal Study of Aging (BLSA) and National Health and Nutrition Examination Survey (NHANES) cohorts also include data that can be utilized to examine sarcopenia. In this study, we examine the validity of a simple clinical symptom index (SARC-F)14 to screen for sarcopenia/dynapenia and to identify those at risk for sarcopenia-related adverse outcomes in AAH, BLSA, and NHANES.

Materials and methods

Study sample

The AAH project sampling and recruitment procedures have been described elsewhere.12 In brief, AAH is a population-based longitudinal study of 998 African Americans from St. Louis, MO. Recruitment was performed using multistage probability sampling methodology designed to select approximately equal numbers of participants from two geographic strata, an inner-city area and near suburban neighbourhoods northwest of the city. AAH eligibility criteria included living independently (i.e. not institutionalized), self-reported black or African American race, birth year between 1936 and 1950, and a Mini-mental State Examination score of 16 or greater (98% ≥). Recruitment proportion (participants/enumerated eligible persons) in 2000–01 was 76%. AAH Wave 1 (baseline) in-home interviews included n = 998 participants evaluated in 2000–01. Follow-up in-home interviews were done at in 2003–04 (Wave 4; n = 853) and 2010–11 (Wave 10; n = 582). The analytic sample for this report includes n = 853 Wave 4 respondents and outcomes at their 6 year follow-up (Wave 10). The institutional review board at Saint Louis University approved this project.

The BLSA was started in 1958 and is an ongoing longitudinal study of normal human aging.15 BLSA participation is limited to adults who at the time of enrollment screening do not have major diseases, cognitive dysfunction, or functional impairment but once enrolled are followed for life. BLSA participants complete comprehensive health testing on a repeated cycle (1–4 years). The analytic sample for this study includes n = 1053 BLSA participants evaluated between April 2003 and December 2012 who were ages 60 and above and had valid data on the five items needed to construct the SARC-F and outcomes at follow-up (27.07 ± 11.7 months).

The NHANES 1999–2006 is an annual cross-sectional, nationally representative survey of approximately 5000 noninstitutionalized individuals in the United States.16 NHANES data are publically released in 2 year cycles. The primary objective of NHANES is to collect a comprehensive data set that can be utilized to assess the health and nutritional status of the national population of children and adults. NHANES data for 1999–2002 include n = 21,004 participants with a median age of 19 (interquartile range 10–48) and 51.4% women. The analytic sample for this study includes n = 3288 NHANES 1999–2002 participants who were ages 60–85 with valid data on the five items needed to construct the SARC-F.

SARC-F questionnaire (0–10 points)

SARC-F includes five components: strength, assistance walking, rise from a chair, climb stairs, and falls. SARC-F items were selected to reflect health status changes associated with the consequences of sarcopenia.3,4 SARC-F scale scores range from 0 to 10 (i.e. 0–2 points for each component; 0 = best to 10 = worst) and were dichotomized to represent symptomatic (4+) vs. healthy (0–3) status. The SARC-F scale was constructed using the same questions in AAH and BLSA. Strength was measured by asking respondents how much difficulty they had lifting or carrying 10 lbs. (0 = no difficulty, 1 = some difficulty, and 2 = a lot or unable to do). Assistance walking was assessed by asking participants how much difficulty they had walking across a room and whether they use aids or need help to do this (0 = no difficulty, 1 = some difficulty, and 2 = a lot of difficulty, use aids, or unable to do without personal help). Climb stairs was measured by asking respondents how much difficulty they had transferring from a chair or bed and whether they used aids or needed help to do this (0 = no difficulty, 1 = some difficulty, and 2 = a lot of difficulty, use aids, or unable to do without personal help). Sarcopenia (0–10 points)

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a chair (assessed by asking difficulty standing up from armless chair). NHANES did not ask participants to report the specific number of falls in the past year but did ask about difficulty with balance or falling in past year. The NHANES SARC-F falls was scored a 2 for respondents who reported falling problems in the past year, 1 for respondents who reported only balance problems in the past year, and 0 for those reporting no falling or balance problems in the past year.

**Criterion validation measures**

We examined the associations of SARC-F with muscle (lean mass per cent and total lean mass) and the short portable sarcopenia measure (SPSM) in the AAH cohort. The portable Tanita Ultimate Scale Model 2001 (Tanita Corporation of America, Arlington Heights, IL) bioelectrical impedance program was used to measure lean mass per cent (1 minus body fat per cent) and total lean mass [(1 minus body fat per cent) x body weight in lbs]. The SPSM scale is a brief field measure for sarcopenia that includes three components: upper body relative strength (grip strength/height), lower body power and strength (timed chair stands), and lean mass [(1 minus body fat per cent) x (body weight in kg/height in m²)], with a potential range of 0–18.17

**Construct validity measures (cross-sectional and longitudinal)**

Instrumental Activity of Daily Living (IADL) difficulty in AAH covered eight items (preparing meals, shopping for groceries, managing money, making phone calls, doing light housework, doing heavy housework, getting to places outside walking distance, and managing medications) from the Second Longitudinal Study on Aging18 and Lawton and Brody19 and was scored as the number of tasks for which the respondent reported difficulty performing or unable to perform it without help. IADL difficulty in BLSA included seven of the eight AAH items except getting to places outside walking distance and was scored as the number of tasks for which the respondent reported difficulty performing or unable to perform without help.

Hospitilation was based on respondent reports of one or more overnight hospitalizations in the year prior to Wave 4 (2004) and Wave 10 (2010) in AAH and of one or more overnight hospitalizations in the year prior to each respondent’s NHANES interview (1999–2002).

For gait speed in AAH, a 3 m or 4 m course in participants’ homes was used, with participants instructed to walk at their usual pace, as if walking to the store. The average walking speed (m/s) for two trials was used to create a dichotomous variable for gait speed average of <0.8 vs. ≥0.8 m/s. A walk course was set up in the testing centre to measure time to complete a 20 ft walk (seconds) in NHANES.

The short physical performance battery (SPPB) measure of lower body performance is based on three component tasks: standing balance, repeated chairs stands, and usual walking speed.20 Each component task was scored as 0–4 (0 = worst to 4 = best), and a composite score was computed as the sum of scores on component tasks as 0–12 (0 = worst to 12 = best). Complete details on the composite SPPB score in AAH are provided by Miller and colleagues.21

Chair stands in AAH were measured as the time (maximum of 60 s) it took participants to complete five rises and returns when instructed to complete the task as fast as possible.

Grip strength testing in AAH was performed in the self-reported stronger hand using either a Jamar (Preston Corp, Jackson, MI) or a baseline (Fabrication Enterprises, Inc., Irvington, NY) isometric dynamometer (pre-testing showed equivalent results using either instrument) and defined as the average (kg) of three maximal trials. Grip strength testing in BLSA was done for both hands and scored as the average (kg) of three trials for each hand separately.

Knee extensor strength testing in NHANES was done using a Kin Com MP dynamometer (Chattanooga Group, Inc., Chattanooga, TN). Peak torque (Newton/metres) of the quadriceps was measured at 60°/s.

Frailty in AAH was measured using the FRAIL scale.11 FRAIL includes five components: fatigue, resistance, ambulation, illness, and loss of weight. FRAIL scores range from 0 to 5 (i.e. 1 point for each component; 0 = best to 5 = worst).

Vital status up to 6 years later in AAH was determined by proxy report as part of the annual AAH follow-up interview plus tracing via local databases (e.g. obituaries). Results were coded 1 for decedents and 0 for survivors. Vital status up to 9.75 years later in BLSA was coded 1 for decedents and 0 for survivors.

**Statistics**

Data were analysed using IBM SPSS Statistics, version 21 (Somers, NY). Descriptive statistics are reported as means ± standard deviations, median and interquartile range, or percentages. T-test for continuous variables and chi-square for categorical variables were used to compare socio-demographic characteristics of study groups. Internal consistency reliability was evaluated using Cronbach’s alpha. Principal components analysis was performed to investigate the homogeneity of SARC-F items. SARC-F associations with muscle mass, SPSM, and frailty were examined using Spearman’s rho correlation. Analysis of covariance (continuous outcomes) and logistic regression (dichotomous outcomes) were used to compare participants with SARC-F scores ≥4 vs. <4 in cross-sectional outcomes. Linear regression (continuous outcomes) and logistic regression (dichotomous outcomes) were used to examine the association of SARC-F score ≥4 vs. <4 for longitudinal outcomes and for SARC-F items with cross-sectional and longitudinal outcomes. Means ± standard deviations are reported for analyses of covariance, adjusted odds ratios (ORs) and 95% confidence
Table 1  Demographic characteristics among participants with high (≥4) vs. low (<4) SARC-F scores

<table>
<thead>
<tr>
<th></th>
<th>SARC-F scores ≥ 4</th>
<th></th>
<th></th>
<th>P-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>African American Health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (mean ± SD)</td>
<td>60.00 ± 4.3</td>
<td>59.95 ± 4.5</td>
<td></td>
<td>0.013</td>
</tr>
<tr>
<td>Women (%)</td>
<td>60.6</td>
<td>71.3</td>
<td></td>
<td>0.019</td>
</tr>
<tr>
<td>Years of education (mean ± SD)</td>
<td>12.69 ± 2.9</td>
<td>11.57 ± 2.8</td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Annual household income below 25 K (%)</td>
<td>44.1</td>
<td>77.1</td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>City area (%)</td>
<td>42.7</td>
<td>55.4</td>
<td></td>
<td>0.004</td>
</tr>
<tr>
<td>Self-rated health: fair or poor (%)</td>
<td>26.3</td>
<td>81.5</td>
<td></td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

| **Baltimore Longitudinal Study of Aging** |                   |          |          |          |
| Age (mean ± SD)           | 85.35 ± 9.2       | 72.74 ± 8.7 |          | <0.001   |
| Women (%)                 | 46.6              | 60.6     |          | 0.019    |
| Race (%)                  |                   |          |          | 0.019    |
| White                     | 74.4              | 89.4     |          | <0.001   |
| Black or African American | 21.0              | 10.6     |          | <0.001   |
| Other race                | 4.6               | 0        |          | <0.001   |
| Years of education (mean ± SD) | 16.81 ± 2.7 | 15.33 ± 3.0 |          | <0.001   |
| Annual household income below 25 K (%) | 4.9            | 16.7     |          | 0.011    |
| Self-rated health: fair or poor (%) | 4.2           | 38.6     |          | <0.001   |

| **National Health and Nutrition Examination Survey** |                   |          |          |          |
| Age (mean ± SD)           | 71.30 ± 7.8       | 75.76 ± 8.2 |          | <0.001   |
| Women (%)                 | 49.1              | 66.5     |          | <0.001   |
| Race (%)                  |                   |          |          | 0.711    |
| Hispanic                  | 3.9               | 4.8      |          | <0.001   |
| Mexican American          | 19.9              | 18.4     |          | <0.001   |
| Other race                | 2.1               | 2.4      |          | <0.001   |
| Less than high school     | 40.8              | 55.2     |          | <0.001   |
| High school/GED           | 24.1              | 20.2     |          | <0.001   |
| More than high school     | 35.1              | 24.6     |          | <0.001   |
| Annual household income below 20 K (%) | 33.1            | 54.5     |          | <0.001   |

GED, general educational development; SD, standard deviation.
* T-test for continuous variables and chi-square for categorical variables.

Table 2  Construct validity: cross-sectional comparisons for health outcomes among participants with high (≥4) vs. low (<4) SARC-F scores

<table>
<thead>
<tr>
<th></th>
<th>SARC-F scores ≥ 4</th>
<th></th>
<th></th>
<th>P-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>African American Health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IADLs (0–8)</td>
<td>0.42 ± 0.9</td>
<td>3.67 ± 2.0</td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Chair stands (s)</td>
<td>11.30 ± 3.5</td>
<td>15.25 ± 5.2</td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Grip strength (kg)</td>
<td>32.52 ± 11.6</td>
<td>26.23 ± 11.1</td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Short physical performance battery (0–12)</td>
<td>8.90 ± 2.3</td>
<td>4.78 ± 3.1</td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hospitalized overnight in the past year</td>
<td>3.94 (2.66–5.83)</td>
<td></td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Gait speed &lt; 0.8 m/s</td>
<td>5.73 (3.28–10.00)</td>
<td></td>
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<td>&lt;0.001</td>
</tr>
</tbody>
</table>

| **Baltimore Longitudinal Study of Aging** |                   |          |          |          |
| IADLs (0–7)              | 0.23 ± 0.7        | 3.74 ± 2.4 |          | <0.001   |
| Grip strength, right hand (kg) | 29.62 ± 10.2 | 17.92 ± 8.4 |          | 0.004    |
| Grip strength, left hand (kg) | 28.25 ± 10.1 | 16.80 ± 8.1 |          | 0.012    |

| **National Health and Nutrition Examination Survey** |                   |          |          | P-value* |
| 20 ft walk (s)           | 6.86 ± 2.58       | 10.18 ± 4.9 |          | <0.001   |
| Peak force, knee extensor strength | 258.15 ± 88.77 | 198.21 ± 69.4 |          | <0.001   |
| Hospitalized overnight in the past year | 2.53 (2.01–3.19) |          |          | <0.001   |

CI, confidence interval; IADLs, Instrumental Activities of Daily Living.
* Analysis of covariance for continuous outcomes and logistic regression for dichotomous outcomes. Analyses adjusted for age and gender.

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intervals (CIs) are reported for logistic regression analyses, and unstandardized (B) regression coefficients and standard errors are reported for linear regression analyses. Cross-sectional analyses were adjusted for age and gender, and longitudinal analyses were adjusted for age, gender, and baseline values of all validating variables except mortality.

### Results

SARC-F total scores (0–10) median (interquartile range) were 0 (0–2) in AAH, 0 (0 and 1) in BLSA, and 0 (0–2) in NHANES. There were 18.4% (157/853) AAH, 6.3% (66/1053) BLSA, and 15.4% (505/3288) NHANES participants with a SARC-F score ≥ 4.

### Table 3 Construct validity: cross-sectional comparisons for health outcomes with SARC-F items*

<table>
<thead>
<tr>
<th></th>
<th>African American Health</th>
<th>Baltimore Longitudinal Study of Aging</th>
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<th>National Health and Nutrition Examination Survey</th>
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<tr>
<td></td>
<td>Unstandardized coefficients</td>
<td></td>
<td>Unstandardized coefficients</td>
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<tr>
<td></td>
<td>B (SE)</td>
<td>P-value</td>
<td></td>
<td>B (SE)</td>
</tr>
<tr>
<td><strong>IADLs (0–8)</strong></td>
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<tr>
<td>Strength</td>
<td>1.55 (0.06)</td>
<td>&lt;0.001</td>
<td>Strength</td>
<td>1.68 (0.07)</td>
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<tr>
<td>Assistance walking</td>
<td>1.97 (0.07)</td>
<td>&lt;0.001</td>
<td>Assistance walking</td>
<td>1.76 (0.07)</td>
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<tr>
<td>Rise from a chair</td>
<td>1.88 (0.08)</td>
<td>&lt;0.001</td>
<td>Rise from a chair</td>
<td>1.39 (0.07)</td>
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<tr>
<td>Climb stairs</td>
<td>1.65 (0.06)</td>
<td>&lt;0.001</td>
<td>Climb stairs</td>
<td>1.48 (0.06)</td>
</tr>
<tr>
<td>Falls</td>
<td>0.92 (0.10)</td>
<td>&lt;0.001</td>
<td>Falls</td>
<td>0.52 (0.07)</td>
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<tr>
<td><strong>Chair stands (s)</strong></td>
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<tr>
<td>Strength</td>
<td>1.89 (0.26)</td>
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<td>Grip strength, right hand (kg)</td>
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<td>Assistance walking</td>
<td>2.76 (0.37)</td>
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<td>Strength</td>
<td>−2.77 (0.63)</td>
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<td>Rise from a chair</td>
<td>2.98 (0.29)</td>
<td>&lt;0.001</td>
<td>Assistance walking</td>
<td>−2.17 (0.62)</td>
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<tr>
<td>Climb stairs</td>
<td>2.35 (0.27)</td>
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<td>Rise from a chair</td>
<td>−1.95 (0.60)</td>
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<tr>
<td>Falls</td>
<td>1.21 (0.29)</td>
<td>&lt;0.001</td>
<td>Climb stairs</td>
<td>−1.81 (0.59)</td>
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<td><strong>Grip strength (kg)</strong></td>
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<tr>
<td>Strength</td>
<td>−2.70 (0.46)</td>
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<td>Grip strength, left hand (kg)</td>
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<tr>
<td>Assistance walking</td>
<td>−1.53 (0.57)</td>
<td>0.007</td>
<td>Strength</td>
<td>−2.60 (0.62)</td>
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<tr>
<td>Rise from a chair</td>
<td>−1.77 (0.58)</td>
<td>&lt;0.001</td>
<td>Assistance walking</td>
<td>−1.71 (0.63)</td>
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<tr>
<td>Climb stairs</td>
<td>−2.53 (0.48)</td>
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<td>Rise from a chair</td>
<td>−1.83 (0.58)</td>
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<tr>
<td>Falls</td>
<td>−1.12 (0.57)</td>
<td>0.051</td>
<td>Climb stairs</td>
<td>−1.65 (0.57)</td>
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<td><strong>SPPB (0–12)</strong></td>
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<tr>
<td>Strength</td>
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<td>Falls</td>
<td>−0.10 (0.44)</td>
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<td>−2.73 (0.17)</td>
<td>&lt;0.001</td>
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<tr>
<td>Rise from a chair</td>
<td>−2.37 (0.18)</td>
<td>&lt;0.001</td>
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<tr>
<td>Climb stairs</td>
<td>−2.33 (0.13)</td>
<td>&lt;0.001</td>
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</tr>
<tr>
<td>Falls</td>
<td>−1.35 (0.18)</td>
<td>&lt;0.001</td>
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<table>
<thead>
<tr>
<th></th>
<th>Odds ratio (95% CI)</th>
<th>P-value</th>
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<tbody>
<tr>
<td>Hospitalized overnight in the past year</td>
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<td></td>
</tr>
<tr>
<td>Strength</td>
<td>2.14 (1.73–2.65)</td>
<td>&lt;0.001</td>
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<tr>
<td>Assistance walking</td>
<td>2.36 (1.85–3.02)</td>
<td>&lt;0.001</td>
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<tr>
<td>Rise from a chair</td>
<td>1.98 (1.54–2.56)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Climb stairs</td>
<td>2.09 (1.67–2.62)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Falls</td>
<td>1.97 (1.49–2.59)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Gait speed &lt; 0.8 m/s</td>
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<tr>
<td>Strength</td>
<td>2.65 (1.96–3.59)</td>
<td>&lt;0.001</td>
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<tr>
<td>Assistance walking</td>
<td>5.02 (2.75–9.15)</td>
<td>&lt;0.001</td>
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<tr>
<td>Rise from a chair</td>
<td>2.92 (1.96–4.36)</td>
<td>&lt;0.001</td>
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<tr>
<td>Climb stairs</td>
<td>3.07 (2.21–4.24)</td>
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<td>Falls</td>
<td>1.49 (1.11–1.99)</td>
<td>0.008</td>
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<td>20 ft walk (s)</td>
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<td>Strength</td>
<td>1.38 (0.09)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Assistance walking</td>
<td>3.21 (0.22)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Rise from a chair</td>
<td>1.55 (0.11)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Climb stairs</td>
<td>1.44 (0.09)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Falls</td>
<td>0.93 (0.10)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Peak force, knee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strength</td>
<td>−16.43 (3.07)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Assistance walking</td>
<td>−32.87 (8.42)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Rise from a chair</td>
<td>−24.22 (3.72)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Climb stairs</td>
<td>−21.89 (3.16)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Falls</td>
<td>−14.12 (3.28)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hospitalized overnight in the past year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strength</td>
<td>1.75 (1.54–1.99)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Assistance walking</td>
<td>1.77 (1.44–2.17)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Rise from a chair</td>
<td>1.68 (1.45–1.94)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Climb stairs</td>
<td>1.73 (1.52–1.97)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Falls</td>
<td>1.62 (1.41–1.86)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

CI, confidence interval; IADLs, Instrumental Activities of Daily Living; SE, standard error; SPPB, short physical performance battery.

* Linear regression for continuous outcomes and logistic regression for dichotomous outcomes. Analyses adjusted for age and gender.

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The characteristics of the SARC-F positive and SARC-F negative groups are shown in Table 1 and demonstrated the expected findings (e.g., lower household income in the SARC-F positive group). The five-item SARC-F alphas were 0.81 (AAH), 0.78 (BLSA), and 0.76 (NHANES). The principal components SARC-F analyses yielded a single factor that accounted for 57.2% (AAH), 56.7% (BLSA), and 53.5% (NHANES) of variance. SARC-F item loadings (AAH, BLSA, and NHANES) were as follows: strength (0.81, 0.80, 0.76), assistance walking (0.81, 0.84, 0.76), rise from a chair (0.80, 0.76, 0.80), climb stairs (0.81, 0.88, 0.80), and falls (0.50, 0.39, 0.49). SARC-F in the AAH cohort correlated with Tanita chair (0.80, 0.76, 0.80), climb stairs (0.81, 0.88, 0.80), and falls (0.81, 0.80, 0.76), assistance walking (0.81, 0.84, 0.76), and the SPSM (r = −0.34; P < 0.001).

**Cross-sectional results**

Health outcomes (disability, physical performance, strength, and utilization) for those with SARC-F ≥4 vs. <4 in the AAH, BLSA, and NHANES cohorts are shown in Table 2. AAH participants with SARC-F scores ≥4 had more IADL deficits than those with SARC-F scores of 3 or less, slower chair stands times, lower grip strength, and lower SPPB scores (P ≤ 0.001). SARC-F scores ≥4 in AAH also were associated with a higher likelihood of being hospitalized overnight in the past year and having a gait speed of <0.8 m/s (P ≤ 0.001). The correlation between total SARC-F scores (0–10) and FRAIL scale scores (0–5) was 0.70 (P < 0.001) in AAH. SARC-F scores ≥4 in BLSA were associated with higher IADL difficulties and worse grip strength in both the right and left hands (P ≤ 0.001). NHANES participants with SARC-F scores ≥4 exhibited slower times to walk 20 ft, lower strength (knee extension), and increased likelihood of being hospitalized overnight in the past year (P ≤ 0.001). Similar associations were seen in cross-sectional comparisons for SARC-F items and outcomes in AAH, BLSA, and NHANES (Table 3).

**Longitudinal results**

SARC-F scores ≥4 predicted hospitalization and gait speed of <0.8 m/s at 6 year follow-up in the AAH (P < 0.05; Table 4). SARC-F scores ≥4 were also associated with more IADL deficits, slower chair stands times, and lower SPPB scores (P ≤ 0.01) at 6 year follow-up in AAH. Grip strength was lower for those with SARC-F scores ≥4 (27 ± 12) vs. <4 (32 ± 11) at 6 year follow-up in AAH, but this difference was not statistically significant (P = 0.288). AAH SARC-F scores ≥4 predicted 6 year mortality (OR = 1.87, 95% CI 1.17–2.98; P = 0.009) and included 19.7% of persons who died compared with 11.9% of non-SARC-F positive persons who died. SARC-F scores ≥4 were associated with more IADL deficits, lower grip strength right hand, and lower grip strength left hand (P ≤ 0.05) at follow-up in BLSA. SARC-F scores ≥4 vs. <4 also predicted mortality (OR = 3.0, 95% CI 1.57–5.73; P < 0.001) in BLSA. Mortality for BLSA participants was 39.4% for SARC-F ≥4 vs. 8.0% for SARC-F < 4. A mortality analysis including only BLSA participants with at least 2 years of follow-up yielded similar results for SARC-F scores ≥4 vs. <4 (OR = 2.69, 95% CI 1.39–5.21; P < 0.001). Similar associations were seen in longitudinal comparisons for SARC-F items and outcomes in AAH and BLSA (Table 5).

**Discussion**

This study demonstrated that a simple clinical score, SARC-F, predicts clinically significant outcomes over the subsequent
Table 5  Construct validity: longitudinal comparisons for health outcomes with SARC-F items*

<table>
<thead>
<tr>
<th>African American Health</th>
<th>Unstandardized coefficients B (SE)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>IADLs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strength</td>
<td>0.53 (0.13)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Assistance walking</td>
<td>−0.04 (0.17)</td>
<td>0.820</td>
</tr>
<tr>
<td>Rise from a chair</td>
<td>0.44 (0.16)</td>
<td>0.005</td>
</tr>
<tr>
<td>Climb stairs</td>
<td>0.78 (0.15)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Falls</td>
<td>0.15 (0.13)</td>
<td>0.246</td>
</tr>
<tr>
<td>Chair stands (s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strength</td>
<td>1.10 (0.60)</td>
<td>0.070</td>
</tr>
<tr>
<td>Assistance walking</td>
<td>2.46 (0.90)</td>
<td>0.007</td>
</tr>
<tr>
<td>Rise from a chair</td>
<td>1.78 (0.86)</td>
<td>0.039</td>
</tr>
<tr>
<td>Climb stairs</td>
<td>1.06 (0.65)</td>
<td>0.107</td>
</tr>
<tr>
<td>Falls</td>
<td>0.08 (0.58)</td>
<td>0.898</td>
</tr>
<tr>
<td>Grip strength (kg) Mortality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strength</td>
<td>−0.40 (0.55)</td>
<td>0.473</td>
</tr>
<tr>
<td>Assistance walking</td>
<td>−0.39 (0.68)</td>
<td>0.561</td>
</tr>
<tr>
<td>Rise from a chair</td>
<td>−0.91 (0.64)</td>
<td>0.161</td>
</tr>
<tr>
<td>Climb stairs</td>
<td>−0.22 (0.57)</td>
<td>0.703</td>
</tr>
<tr>
<td>Falls</td>
<td>−0.37 (0.63)</td>
<td>0.559</td>
</tr>
<tr>
<td>Short physical performance battery (0–12)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strength</td>
<td>−0.68 (0.22)</td>
<td>0.002</td>
</tr>
<tr>
<td>Assistance walking</td>
<td>−0.45 (0.30)</td>
<td>0.131</td>
</tr>
<tr>
<td>Rise from a chair</td>
<td>−1.06 (0.25)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Climb stairs</td>
<td>−1.05 (0.23)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Falls</td>
<td>0.11 (0.24)</td>
<td>0.649</td>
</tr>
<tr>
<td>Hospitalized overnight in the past year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strength</td>
<td>1.67 (1.27–2.21)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Assistance walking</td>
<td>1.55 (1.11–2.17)</td>
<td>0.010</td>
</tr>
<tr>
<td>Rise from a chair</td>
<td>2.06 (1.51–2.83)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Climb stairs</td>
<td>1.52 (1.13–2.05)</td>
<td>0.006</td>
</tr>
<tr>
<td>Falls</td>
<td>1.83 (1.29–2.59)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Gait speed &lt; 0.8 m/s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strength</td>
<td>1.33 (0.87–2.02)</td>
<td>0.182</td>
</tr>
<tr>
<td>Assistance walking</td>
<td>1.43 (0.78–2.62)</td>
<td>0.254</td>
</tr>
<tr>
<td>Rise from a chair</td>
<td>1.71 (1.00–2.92)</td>
<td>0.050</td>
</tr>
<tr>
<td>Climb stairs</td>
<td>1.50 (0.96–2.35)</td>
<td>0.077</td>
</tr>
<tr>
<td>Falls</td>
<td>0.79 (0.52–1.21)</td>
<td>0.278</td>
</tr>
<tr>
<td>Mortality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strength</td>
<td>1.43 (1.11–1.85)</td>
<td>0.005</td>
</tr>
<tr>
<td>Assistance walking</td>
<td>1.43 (1.07–1.90)</td>
<td>0.015</td>
</tr>
<tr>
<td>Rise from a chair</td>
<td>1.26 (0.92–1.75)</td>
<td>0.147</td>
</tr>
<tr>
<td>Climb stairs</td>
<td>1.59 (1.21–2.02)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Falls</td>
<td>1.04 (0.74–1.49)</td>
<td>0.807</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Baltimore Longitudinal Study of Aging</th>
<th>Unstandardized coefficients B (SE)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>IADLs (0–7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strength</td>
<td>0.30 (0.11)</td>
<td>0.007</td>
</tr>
<tr>
<td>Assistance walking</td>
<td>0.74 (0.11)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Rise from a chair</td>
<td>0.44 (0.10)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Climb stairs</td>
<td>0.29 (0.11)</td>
<td>0.007</td>
</tr>
<tr>
<td>Falls</td>
<td>0.10 (0.07)</td>
<td>0.151</td>
</tr>
<tr>
<td>Grip strength, right hand (kg)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strength</td>
<td>−1.32 (0.62)</td>
<td>0.035</td>
</tr>
<tr>
<td>Assistance walking</td>
<td>−0.94 (0.62)</td>
<td>0.129</td>
</tr>
<tr>
<td>Rise from a chair</td>
<td>−1.56 (0.56)</td>
<td>0.006</td>
</tr>
<tr>
<td>Climb stairs</td>
<td>−1.18 (0.59)</td>
<td>0.045</td>
</tr>
<tr>
<td>Falls</td>
<td>−0.15 (0.37)</td>
<td>0.695</td>
</tr>
<tr>
<td>Grip strength, left hand (kg)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strength</td>
<td>−0.18 (0.69)</td>
<td>0.800</td>
</tr>
<tr>
<td>Assistance walking</td>
<td>−1.17 (0.70)</td>
<td>0.097</td>
</tr>
<tr>
<td>Rise from a chair</td>
<td>−1.99 (0.59)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Climb stairs</td>
<td>−0.78 (0.65)</td>
<td>0.229</td>
</tr>
<tr>
<td>Falls</td>
<td>−0.49 (0.39)</td>
<td>0.215</td>
</tr>
</tbody>
</table>

(Continues)
The objective of case finding is to identify persons at high risk for adverse outcomes. Based on these findings, SARC-F would be an adequate tool to identify persons with muscle weakness that may be amenable to treatment. At present, the major treatment would be resistance exercise and possibly other forms of exercise coupled with increased protein intake. This study suggests that SARC-F is a rapid, question-based clinical tool that may be a useful sarcopenia screen for primary care physicians. This would then allow referral of persons with positive SARC-F scores for further evaluation and to involve them in resistance exercise programmes. Testosterone may be useful, but its safety has been questioned. A number of drugs such as selective androgen receptor molecules, myostatin inhibitors, and ghrelin agonists are being developed to treat sarcopenia; if and when proven effective, they may benefit SARC-F positive patients.

This approach is similar to the one emerging for fracture risk. Two studies have shown that using the questions included in the FRAX risk assessment tool (www.shef.ac.uk/FRAX), the population can be divided into low risk, intermediate risk, and high risk. If BMD is only measured in those at intermediate risk, the need to measure BMD is avoided in 70% of the population. Selective use of BMD testing had a sensitivity of 87% for identifying fragility fractures. As commonly used definitions of sarcopenia require low gait speed and an appendicular muscle mass corrected for height squared, it would seem that those who are SARC-F positive might need to undergo this more extensive testing.

This study has limitations. There were some differences in the items used to construct the SARC-F in AAH and BLSA vs. NHANES. In particular, the SARC-F falls item computed using the NHANES cohort data did not include the number of falls in the past year but rather whether respondents had balance problems or falling problems in the past year. NHANES respondents with falling problems may have had fewer than four falls in the past year, and those who report balance problems but not falling problems may not have had any falls in the past year. Thus, we were not able to determine the number of falls for NHANES respondents, so we were only able to approximate the SARC-F falls item and scoring in NHANES via self-reported balance or falling problems.

Some outcomes were not available in all cohorts, or the valid sample size was too small for some outcomes to be included in this study. Another limitation is that the AAH cohort included late middle-aged adults at baseline, so the prevalence of sarcopenia among African Americans likely would be higher in an older cohort. On the other hand, late middle age is probably a good time to identify sarcopenia so that it can be stabilized or reversed in time to prevent adverse outcomes, and African Americans are more likely to have frailty. The BLSA cohort does include older adults, but this group is high functioning when enrolled in the study. SARC-F correlations with the performance-based SPSM (AAH) and with muscle mass by bioelectrical impedance (AAH) were modest overall. Thus, additional studies are needed to examine SARC-F’s validity in other populations and against standard definitions of sarcopenia (e.g. European Working Group on Sarcopenia in Older People) in prospective studies and to investigate the ability of treatment programs to lower SARC-F scores or prevent adverse outcomes in patients with SARC-F positive. There are currently no data available on the optimal interval or age to screen for sarcopenia. Empirical evidence is also needed to demonstrate that sarcopenia interventions have efficacy for clinical outcomes prior to screening for this syndrome in primary care.

In summary, we developed a simple self-report questionnaire (SARC-F) to screen for persons with sarcopenia. The SARC-F includes five items based on cardinal features or consequences of sarcopenia. This study provides evidence that the SARC-F scale in AAH, BLSA, and NHANES cohorts is internally consistent and valid for detecting persons at risk for adverse outcomes from sarcopenia.

### Acknowledgements

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### Conflict of interest

None declared.
References


