**Appendix A.**

In order to register comorbid conditions patients were asked about them and both their medical records as well as their medication charts were reviewed. Whenever discrepancies or inconsistencies were found the general practitioners were contacted.

The specific comorbidities considered were:

* Congestive heart failure (CHF)
* Ischemic heart disease
* Peripheral vascular disease
* Atrial fibrillation (AF): current or paroxistic on anticoagulant treatment (past history of AF, or AF successfully ablated was not considered)
* Hypertension
* Chronic obstructive pulmonary disease (COPD): no distinction was made among the specific entities comprised within this overarching concept. It was considered to be present whenever patients with such a diagnosis were on broncodilating treatment, or at least in Stage II according to the GOLD guidelines(1) (none of our cases was on home oxygen therapy).
* Anemia: as defined by the World Health Organization criteria.(2)
* Cerebrovascular accident
* Diabetes
* Chronic renal failure
* Neoplasms: stages of neoplasic disease were not recorded. (However, metastatic fractures were considered as a surrogate measure of advanced cancer).
* Parkinson’s disease
* Osteoporosis/oteoporosis-related fractures (excluding metastatic fractures)
* Arthrosis
* Sensory problems (blindness, deafness).

**Appendix B.**

Functional reserve was measured through a questionnaire based on the Compendium of Physical activities.(3) Patients were asked whether they were capable of carrying out any of the following activities. A single activity from Group 2 was enough to consider that the functional reserve was normal.

Group 1

Any of the following activities requires up to 3 METS:

* Eating /drinking
* Geting dressed
* Going to the toilet on one´s own
* Walking wihtin the house
* Walking 100 meters on a flat surface

Group 2:

Any of the following activities requires more than 3 METS:

* Climbing up a flight of stairs
* Walking 100 meters up a slope
* Mopping the floor, general cleaning
* Lifting items repeatedly (4.5-9kg)
* Playing with animals, bathing pets
* Tailoring, weaving

**Appendix C:**

A postoperative complication was considered to be clinically relevant if it required specific treatment, further work-up, longer stay in a critical care unit or transfer to a higher acuity ward.(4)

* Cardiovascular complications: diagnosis of myocardial infaction (chest pain, electrocardiogram, enzymes), clinical symptoms of CHF (dyspnea, reduced O2 saturation, rales or crakles, S3, characteristic X-ray), new monitored arrhythmia (atrial or ventricular).(4)
* Respiratory complications: clinical diagnosis of pneumonia (dyspnea, fever, rhonci, new X-ray infiltrates, cough, sputum, positive cultures), prolonged intubation or reintubation due to clinical respiratory failure, exacerbation of COPD, adult respiratroy dystress syndrome (non-cardiac bilateral infiltrates in X-rays, paO2/FiO2 ≤ 200), pulmonary embolus (diagnosis required ventilation-perfusion scan or spiral CT scan).
* Disorientation/delirium: as defined by Dasgupta et al.(5)
* Cerebrovascular accident: neurologic deficit on physical examination, or evidence on CT scan.
* Hydro-electrolyte imbalance: abnormalities in the levels of sodium, potassium or calcium with clinical symptoms, or which required treatment for more than 24 hours (hypokalemia corrected with a 30mEq-bolus of ClK did not qualify as a hydro-electrolyte complication).
* Infection: wound or any other as long as they required surgical or antibiotic treatment.
* Hemorrhage (during the postoperative period, bleeding in theatre was not considered)
* Abdominal complications: anastomotic leaks, persistent ileus, evisceration, peritonitis, most diagnosis were clinical, although in some cases a CTscan was needed.
* Acute kidney injury, as defined by the Acute Kidney Injury Network (2007)(6)
* Urinary tract infection
* Sepsis.(7)

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