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REVIEW

Management of acute heart failure in elderly patients



La prise en charge de l'insuffisance cardiaque aiguë chez les patients âgés

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Summary Acute heart failure (AHF) is the most common cause of unplanned hospital admissions, and is associated with high mortality rates. Over the next few decades, the combination of improved cardiovascular disease survival and progressive ageing of the population will further increase the prevalence of AHF in developed countries. New recommendations on the management of AHF have been published recently, but as elderly patients are under-represented in clinical trials, and scientific evidence is often lacking, the diagnosis and management of AHF in this population is challenging. The clinical presentation of AHF, especially in patients aged > 85 years, differs substantially from that in younger patients, with unspecific symptoms, such as fatigue and confusion, often overriding dyspnoea. Older patients also have a different

Abbreviations: AHF, acute heart failure; BNP, B-type natriuretic peptide; CCU, cardiac care unit; HFpEF, heart failure with preserved ejection fraction; HFrEF, heart failure with reduced ejection fraction; ICU, intensive care unit; NT-proBNP, N-terminal pro-B-type natriuretic peptide; SpO₂, peripheral oxygen saturation.

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risk profile compared with younger patients: often heart failure with preserved ejection fraction, and infection as the most frequent precipitating factor of AHF. Moreover, co-morbidities, disability and frailty are common, and increase morbidity, recovery time, readmission rates and mortality; their presence should be detected during a geriatric assessment. Diagnostics and treatment for AHF should be tailored according to cardiopulmonary and geriatric status, giving special attention to the patient's preferences for care. Whereas many elderly AHF patients may be managed similarly to younger patients, different strategies should be applied in the presence of relevant co-morbidities, disability and frailty. The option of palliative care should be considered at an early stage, to avoid unnecessary and harmful diagnostics and treatments.

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MOTS CLÉS

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cardiaque aiguë ;
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Résumé L'insuffisance cardiaque aiguë (ICA) est la première cause d'hospitalisations non programmées chez les personnes âgées. Elle est associée à des taux élevés de mortalité. Dans les pays développés, dans les prochaines décennies, l'amélioration de la survie des maladies cardiovasculaires, combinée au vieillissement de la population, va encore accroître sa prévalence. De nouvelles recommandations sur la prise en charge de l'ICA ont été récemment publiées, mais les preuves scientifiques concernant les patients âgés font souvent défaut car cette catégorie de patients sont sous-représentées dans les essais cliniques. Le diagnostic et la gestion de l'ICA dans cette population reste un défi. La présentation clinique de l'ICA, en particulier chez les patients âgés de plus de 85 ans, diffère sensiblement de celles des patients plus jeunes. Des symptômes non spécifiques tels que la fatigue et la confusion peuvent être au premier plan, bien plus que la dyspnée. Les patients âgés ont également un profil de risque différent des patients plus jeunes, en particulier avec la présence d'insuffisance cardiaque à fraction d'éjection conservée. Les infections sont des facteurs précipitant fréquents l'ICA. En outre, les comorbidités, le handicap, et la fragilité sont fréquents et augmentent la morbidité, le temps de récupération, les taux de réadmission, ainsi que la mortalité. Leur présence doit être recherchée au cours d'une évaluation gériatrique. Le diagnostic et le traitement de l'ICA doivent être adaptés à l'état cardiopulmonaire et à l'évaluation gériatrique, en accordant une attention particulière aux préférences des patients. Alors que de nombreux patients âgés atteints d'ICA peuvent être pris en charge comme les patients plus jeunes, des stratégies alternatives devraient être considérées en présence de comorbidités, de handicap et de fragilité significatifs. Les soins palliatifs devraient être envisagés dès la phase initiale dans certaines situations, afin d'éviter des traitements inutiles et/ou des démarches diagnostiques lourdes et délétères.

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Background

Acute heart failure (AHF) is the term used to describe the rapid onset of symptoms and signs of heart failure [1]; it is a life-threatening condition with substantial short- and long-term mortality [2], which requires rapid diagnosis and treatment delivery to relieve symptoms and improve outcome.

AHF is currently the most common cause of unplanned hospital admissions in patients aged > 65 years in the Western World. The average age of patients admitted for AHF is 75 years, and specialists in geriatrics are increasingly involved in the interdisciplinary management of patients with AHF. Over the next few decades, the prevalence of AHF will increase further, especially in elderly patients, because of the combination of improved cardiovascular disease survival and progressive ageing of the population in developed countries [3].

New recommendations for the management of patients with AHF were published recently [4]. "Young" (aged < 64 years) and "middle old" patients (aged 65–74 years) represent the typical AHF population, and can be managed according to general guidelines [1,4]. However, because "old old" patients (aged 75–84 years) and, in particular, with increasing age, "oldest old" patients (aged > 85 years) differ substantially from younger patients in terms of the clinical characteristics of AHF and the prevalence of co-morbidities, disability and frailty, a reappraisal of the topic, with a special focus on elderly patients, is warranted.

In the present paper, we review current evidence and, as older patients are under-represented in clinical trials and evidence for an optimal treatment option for this special subgroup is lacking, we have added expert opinion, to provide guidance to practicing physicians and other health-care professionals involved in the management of elderly patients (aged > 75 years) with AHF.

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