



Consensus statement

Chronic ischaemic heart disease in the elderly^{☆,☆☆}

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ABSTRACT

It is the aim of this manuscript to take into account the peculiarities and specific characteristics of elderly patients with chronic ischaemic heart disease from a multidisciplinary perspective, with the participation of the Spanish Society of Cardiology (sections of Geriatric Cardiology and Ischaemic Heart Disease/Acute Cardiovascular Care), the Spanish Society of Internal Medicine, the Spanish Society of Primary Care Physicians and the Spanish Society of Geriatrics and Gerontology.

This consensus document shows that in order to adequately address these elderly patients a comprehensive assessment is needed, which includes comorbidity, frailty, functional status, polypharmacy and drug interactions. We conclude that in most patients medical treatment is the best option and that this treatment must take into account the above factors and the biological changes associated with ageing.

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Cardiopatía isquémica crónica en el anciano

RESUMEN

Este artículo pretende tener en cuenta las peculiaridades y características específicas de los pacientes ancianos con cardiopatía isquémica crónica desde una perspectiva multidisciplinar, con la participación de la Sociedad Española de Cardiología (secciones de Cardiología Geriátrica y Cardiopatía Isquémica/Cuidados Agudos Cardiovasculares), la Sociedad Española de Medicina Interna, la Sociedad Española de Médicos de Atención Primaria y la Sociedad Española de Geriatria y Gerontología.

En este documento de consenso se detalla cómo el abordaje de estos enfermos de edad avanzada exige una valoración integral de la comorbilidad, la fragilidad, el estado funcional, la polifarmacia y las interacciones medicamentosas. Concluimos que en la mayoría de los pacientes el tratamiento médico es la mejor opción y que, a la hora de programarlo, se deben tener en cuenta los factores anteriores y las alteraciones biológicas asociadas al envejecimiento.

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Palabras clave:

Cardiopatía isquémica

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Rationale

Decision making regarding diagnosis, treatment and care of elderly patients with chronic ischaemic heart disease should combine the influence of heterogeneity among the elderly, the coexistence of multiple comorbidities, frequent in this population, and the polypharmacy associated with it, the functional status in daily life and the biological differences associated with ageing.¹ Non-specific symptoms are often found in the elderly such as

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^{☆☆} Consensus document of the Spanish Society of Cardiology (Geriatric Cardiology and Ischaemic Heart/Cardiovascular Acute Care sections), the Spanish Society of Internal Medicine, the Spanish Society of Primary Care Physicians and the Spanish Society of Geriatrics and Gerontology.

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dizziness, fatigue and others that can interfere with symptoms of ischaemic heart disease and make the differential diagnosis difficult. To all of these, we must add the fact that the care and treatment based on evidence, recommended to us by clinical guidelines, have been established from clinical trials in which the elderly are underrepresented. Because of these, decision-making throughout the whole process requires the completion of a patient-centred plan that also incorporates their wishes and expectations. In this context, the priority may be to maintain patient independence, improve their quality of life and prevent hospital admissions, rather than prolong survival.

The good clinical practice guidelines are a good help for doctors facing an up-to-date approach of different diseases. In the last 2 years, a new *European Society of Cardiology*² guide and an update of the *American Heart Association*³ guide have been published in the field of stable ischaemic heart disease. These recommendations emphasize those subgroups that stand out due to their prevalence, impact and specific characteristics. As a result of the progressive ageing of the population, and the advances in the treatment of acute coronary syndrome,⁴ the number of elderly patients with stable ischaemic heart disease has increased. While the guidelines establish specific recommendations for elderly patients, only one⁵ out of the 7 major clinical trials comparing revascularization with medical treatment was performed in a population over 75 years of age. In the other 6 trials, the inclusion of subjects over 65 years did not exceed 30%. This lack of data is disturbing, given the specific and peculiar characteristics of this population. The mortality associated with chronic ischaemic heart disease increases with age.⁶ The development of heart failure⁷ and the presentation of complications after percutaneous and surgical coronary interventions is more frequent in the elderly.⁸ In addition, asymptomatic and/or atypical presentations are more common in those over 75 years of age⁹ and some diagnostic tests may be more complex to perform or have a lower diagnostic yield.^{10,11} Also the percentage of patients who comply with medical treatment decreases significantly with age,¹² not exceeding 33 and 50% before and after revascularization, respectively.¹³ On the other hand, in the elderly population, the response to aspirin is decreased,¹⁴ the efficacy of statins is lower,¹⁵ adverse effects are more frequent¹⁶ and beta-blockers are prescribed less frequently and are associated with higher discontinuation,¹⁷ and with a worse heart rate control.^{18,19} The underuse of aspirin and renin-angiotensin system inhibitors has also been documented, more significantly in those over 80 years of age.²⁰

Methodology, receivers, objective and recommendations

Prior to the writing of this manuscript, during the months of June to October 2015 interactive searches were conducted in the MEDLINE® database to find the articles related to the care of the elderly with chronic ischaemic heart disease. Search terms included “angina pectoris”, “stable coronary artery disease”, “risk factors”, “anti-ischaemic drugs”, “coronary revascularization”, “elderly”, “chronic ischaemic heart disease”, “comorbidity”, “frailty”, “functional status”, “polypharmacy”, “drug interactions” and “aging”. No specific keywords required as inclusion criteria were used. Reference lists of each article were reviewed in detail to find additional articles. Those studies specifically conducted in the elderly or that provided a subgroup analysis in elderly patients were selected.

This consensus document is intended for all healthcare professionals who are involved in caring for elderly patients with chronic ischaemic heart disease. It aims to provide clear guidelines for diagnosis and treatment that take into account the specific characteristics of this population from a multidisciplinary perspective, enabling a comprehensive assessment of elderly patients. Specifically, this manuscript is focused on subjects over 80 years of

age or over 75 years with comorbidity and/or frailty. Future possible updates of this document would be conducted by experts appointed by the scientific societies involved.

The recommendations in this document are based on previous scientific evidence, specific for the elderly, regarding measures that improve their survival, symptom control and/or quality of life, taking into account the side effects and risks of the various measures. The fact that all medical societies engaged in the care of these patients are involved in the preparation of this manuscript will facilitate its dissemination, implementation and monitoring, integrating the new evidence. Our recommendation is that this is always done from a multidisciplinary perspective, because otherwise the global approach required by these patients would be lost. For these recommendations to be put into practice close contact between all professionals who diagnose and treat these patients is essential.

Epidemiology

Chronic ischaemic heart disease encompasses a variety of clinical conditions including stable angina, asymptomatic patients after an acute coronary syndrome, vasospastic angina and microvascular angina. Consequently, its prevalence depends on the highly variable selection criteria used in different studies. As regards symptomatic patients, the Fibrillation and Coronary Heart Disease Observation study has recently been published in Spain (OFRECE),²¹ which included 8378 individuals and whose objective was to calculate the prevalence of angina among the Spanish general population using the Rose questionnaire as the classification variable. The adjusted prevalence in the overall population was 2.6%, increasing to 7.1% for the population aged 70–79 years. However, in the population aged 80 or older, the prevalence decreased to 5.6%, which could be explained in part by the increased mortality from cardiovascular disease in this population. If the results are compared with 2 previous studies conducted in Spain,^{22,23} a reduction is observed in the prevalence (7.6 and 3.5% compared to 2.6% of the OFRECE study), which can be explained by the different selection criteria. These data are somewhat lower than those published by the USA Institute of Health, which estimated an angina prevalence of 12–14% in men and 10–12% in women in the 65–84-year-old population.²⁴ Regarding the prevalence of angina among patients with chronic ischaemic heart disease, the most relevant data come from the multinational *Prospective Observational Longitudinal Registry of Patients with Stable Coronary Artery Disease – CLARIFY* –²⁵ European study conducted in 32,724 patients. While there are notable differences between regions, the overall prevalence of angina was 22%, equal to that of the Spanish cohort.²⁶ If we focus on the incidence of angina rather than in its prevalence, the rate goes from 1% per year in the population under 65 years of age up to 4% in the age range of 75–84 years.²⁴ With regard to the incidence of angina as initial symptom, recent data show a reduction in the age range of 70–79 years and those over 80 years versus those under 70 years.²⁷ Finally, with regard to mortality in stable angina, it is highly variable depending on the clinical, functional and anatomical characteristics, ranging from 1.2 to 2.4% per year.²⁸ In general, poor prognostic factors are more common in the population over 65 years of age, therefore, these mortality rates are probably higher in this population group.

Diagnosis

Clinical and lab test history

Coronary heart disease can be difficult to diagnose in the elderly. The clinical presentation is often atypical or manifests as

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