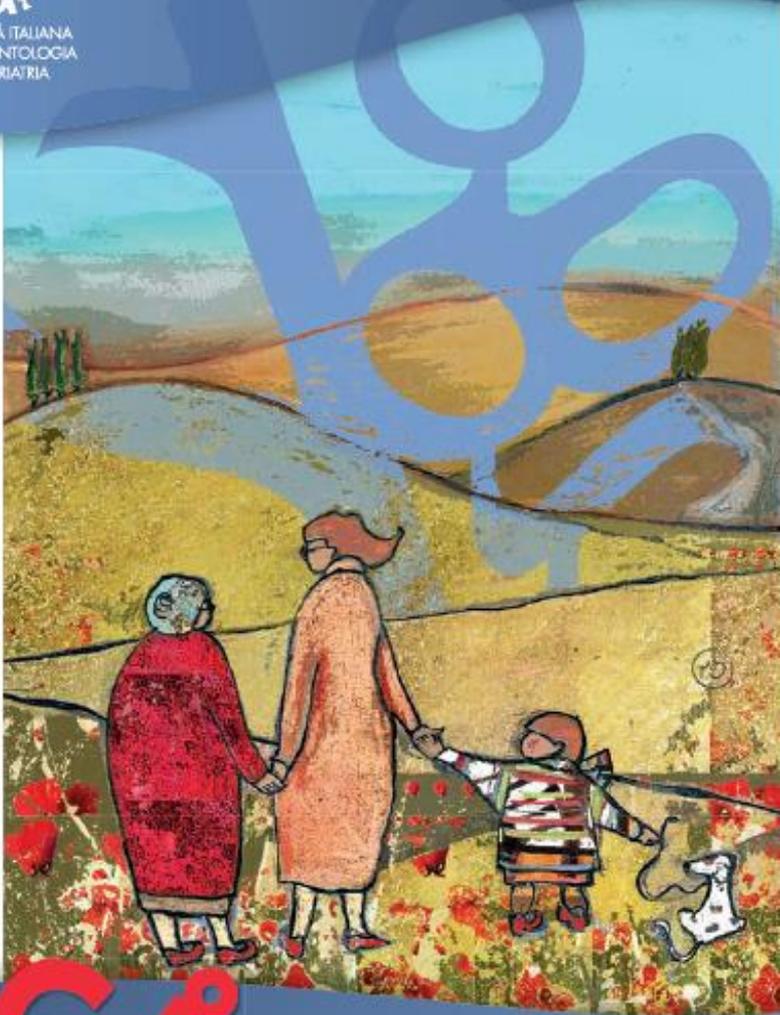




SOCIETÀ ITALIANA
DI GERONTOLOGIA
E GERIATRIA

PROGRAMMA DEFINITIVO



64

**CONGRESSO
NAZIONALE SIGG**

Continuità di affetti, continuità di cure

ROMA, 27/30 NOVEMBRE 2019 - AUDITORIUM DELLA TECNICA

MEET THE EXPERT SIGG-SICGe

**CARDIOPATIA ISCHEMICA STABILE: UNA PATOLOGIA INVALIDANTE
NEL PAZIENTE ANZIANO. TRATTAMENTO FARMACOLOGICO O
RIVASCOLARIZZAZIONE?**

Moderatori: Alessandro Boccanelli (Roma), Niccolò Marchionni (Firenze)

**Importanza
dell'ottimizzazione del
trattamento
farmacologico
sull'outcome
cardiovascolare e sulla
qualità di vita**

Samuele Baldasseroni (Firenze)

...quando mi sono chiesto cosa si deve valutare per ottimizzare la terapia farmacologica nell' anziano con cardiopatia ischemica cronica **tre DILEMMI** mi sono sembrati evidenti.....

- **Di quale fenotipo clinico-fisiopatologico di cardiopatia ischemica cronica vogliamo discutere.**
- **Su quali evidenze cliniche dobbiamo basarsi**
- **Su quali OUTCOMES dobbiamo valutare l'efficacia delle diverse terapia farmacologiche**



...studiando studiando mi sembrano evidenti questi 4 KEY Messages...

- Esistono molteplici **FENOTIPI CLINICI** con diverso profilo di rischio ed impatto clinico sintomatologico.
- Esistono terapie e farmaci che agiscono sulla sintomatologia anginosa (**ANGINA relief**) e altri sulla prevenzione degli eventi cardiovascolari (**DISEASE modifiers**)
- Lo stesso farmaco può avere effetti **positivi o neutri** sui diversi fenotipi clinici della cardiopatia ischemica cronica (es. **RANOLAZINA**)
- Ma non bisogna dimenticare che in buona parte dei Fenotipi clinici una terapia farmacologica ottimizzata (**OMT**) è efficace **TANTO-QUANTO** una strategia invasiva (**ISCHEMIA trial-message**)

...I fenotipi Clinici delle -Chronic Coronary Syndromes-...



Chronic coronary syndromes

Six common scenarios at outpatient clinics



Patients with suspected CAD and 'stable' anginal symptoms, and/or dyspnoea



Patients with new onset of HF or LV dysfunction and suspected CAD



Patients with stabilized symptoms <1 year after an ACS or patients with recent revascularization



Patients >1 year after initial diagnosis or revascularization



Patients with angina and suspected vasospastic or microvascular disease



Asymptomatic subjects in whom CAD is detected at screening

2019 ESC Guidelines for the diagnosis and management of chronic coronary syndromes

In patients with a high risk of ischaemic events

Diffuse multivessel CAD with at least one of the following:

- diabetes mellitus requiring medication
- recurrent MI
- PAD
- CKD with eGFR 15-59 mL/min/1.73 m².

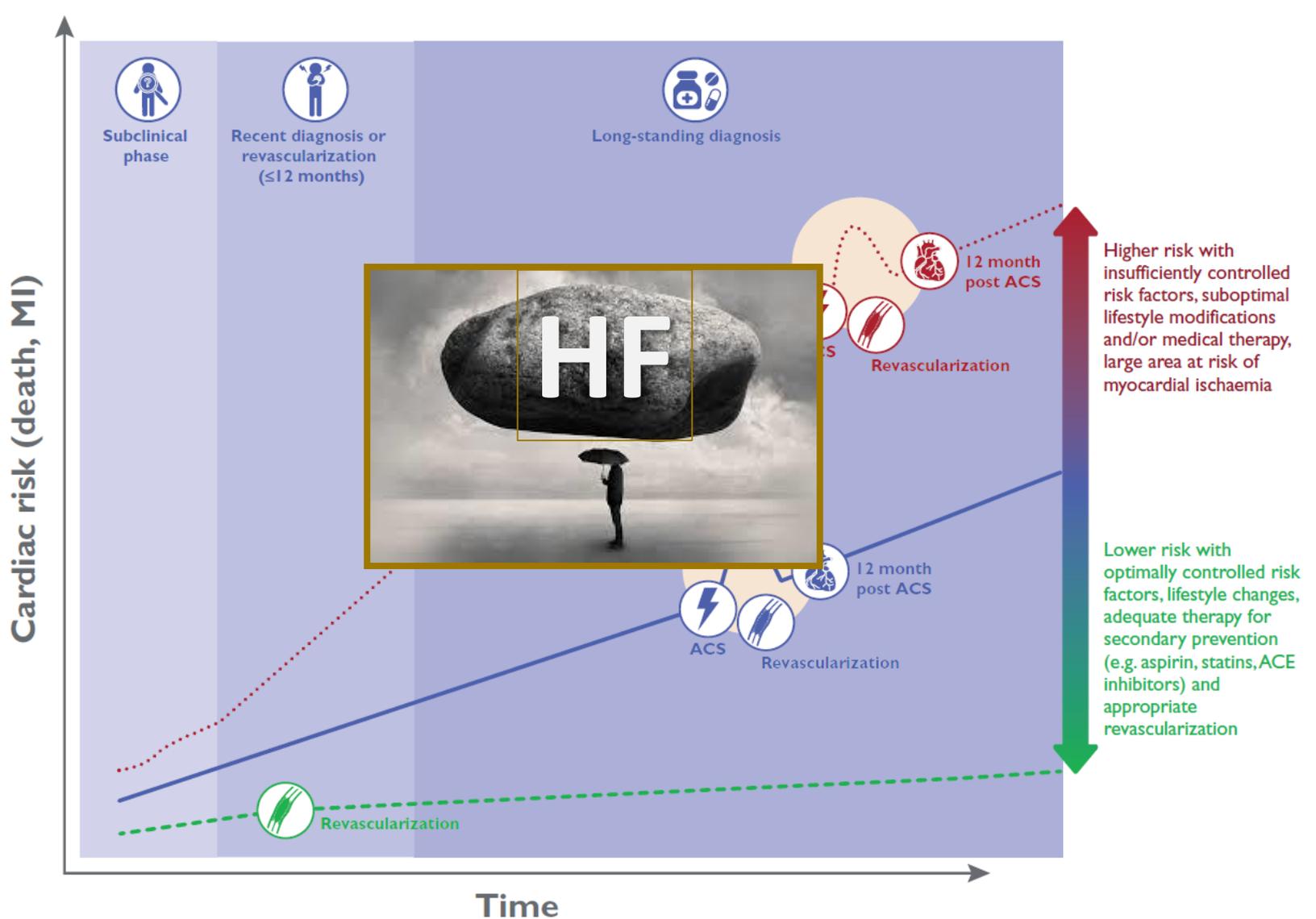
In patients with a moderately increased risk of ischaemic events

CCS with at least one of the following:

- multivessel/diffuse CAD
- diabetes mellitus requiring medication
- recurrent MI
- PAD
- HF
- CKD with eGFR 15-59 mL/min/1.73 m²

2019 ESC Guidelines for the diagnosis and management of chronic coronary syndromes

the natural history of chronic coronary syndromes.



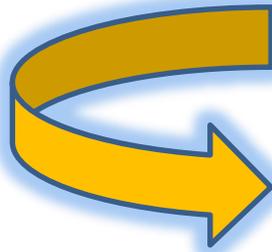


2019 ESC Guidelines for the diagnosis and management of chronic coronary syndromes

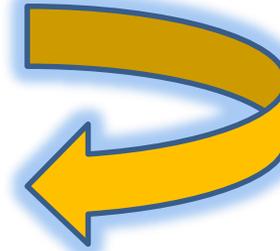
The Task Force for the diagnosis and management of chronic coronary syndromes of the European Society of Cardiology (ESC)

Documento di consenso ANMCO/GICR-IACPR/SICI-GISE: La gestione clinica del paziente con cardiopatia ischemica cronica

Carmine Riccio¹ (Coordinatore), Michele Massimo Gulizia² (Coordinatore), Furio Colivicchi³ (Coordinatore), Andrea Di Lenarda⁴ (Coordinatore), Giuseppe Musumeci⁵, Pompilio Massimo Faggiano⁶, Maurizio Giuseppe Abrignani⁷, Roberta Rossini⁸, Francesco Fattiroli⁸, Serafina Valente⁹, Gian Francesco Mureddu¹⁰, Pier Luigi Temporelli¹¹, Zoran Olivari¹², Antonio Francesco Amico¹³, Giancarlo Casolo¹⁴, Claudio Fresco¹⁵, Alberto Menozzi¹⁶, Federico Nardi¹⁷



**Più dubbi che certezze
sulla terapia**



November 2019-AHA congress



ISCHEMIA-Trial results

Presented by **Judith S. Hochman** at the American Heart Association Annual Scientific Sessions (AHA 2019), Philadelphia, PA, November 16, 2019.

Interpretation:

Among patients with stable ischemic heart disease and moderate to severe ischemia on noninvasive stress testing, routine **invasive therapy failed to reduce major adverse cardiac events compared with optimal medical therapy.**

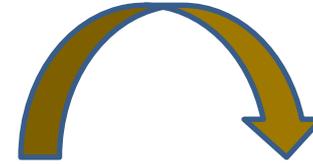
There was also no benefit from invasive therapy regarding all-cause mortality or cardiovascular mortality/myocardial infarction. One-third of subjects reported no angina symptoms at baseline.

Routine invasive therapy was associated with harm at 6 months (increase in periprocedural myocardial infarctions) and associated with benefit at 4 years (reduction in spontaneous myocardial infarction).

These results do not apply to patients with current/recent acute coronary syndrome, highly symptomatic patients, left main stenosis, or left ventricular ejection fraction <35%.

Although the overall interpretation of this trial was negative, there were mixed findings with evidence for both harm and benefit. This signals that:

- 1) invasive therapy for stable ischemic heart disease patients needs to be carefully considered in the context of angina burden and background medical therapy, and
- 2) likelihood that optimal coronary revascularization can be achieved with low procedural complications.

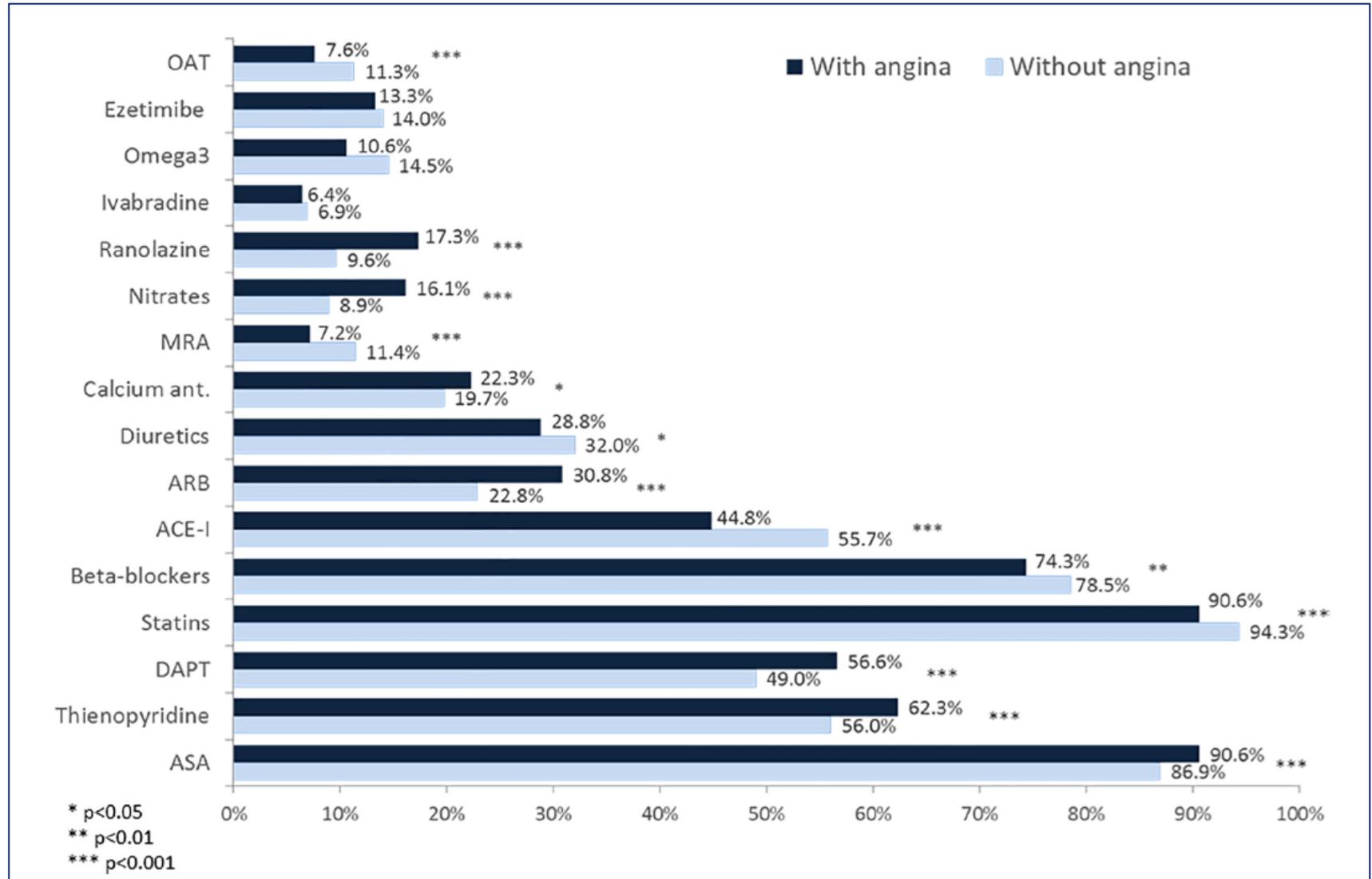


Optimal Medical Therapy (ies)
È un opzione terapeutica
valida.....

e.. forse bisognerebbe almeno
smetterla di definirla in modo
Subdolamente spregiativo

Conservative therapy

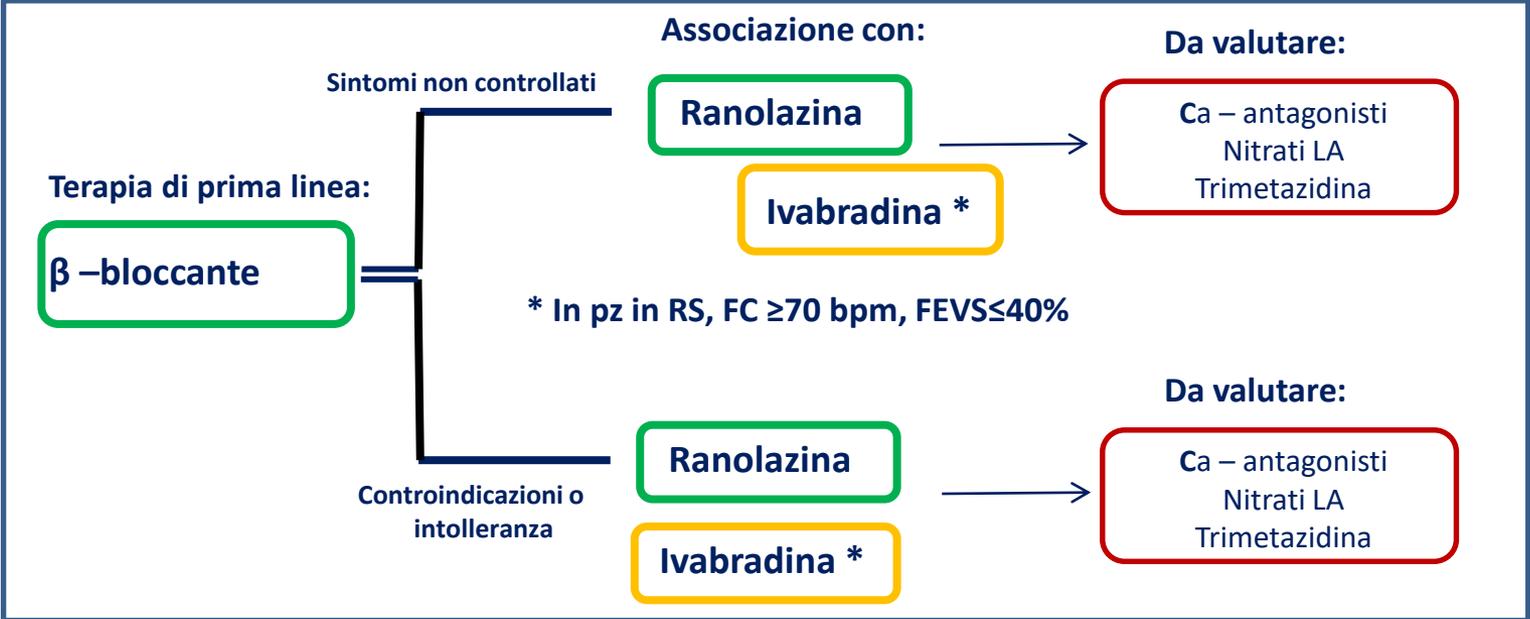
Treatment of stable coronary artery disease patients with or without angina: Insights from the START study



...Angina relief therapies (ANMCO point of view)...



Documento di consenso ANMCO/GICR-IACPR/SICI-GISE: La gestione clinica del paziente con cardiopatia ischemica cronica



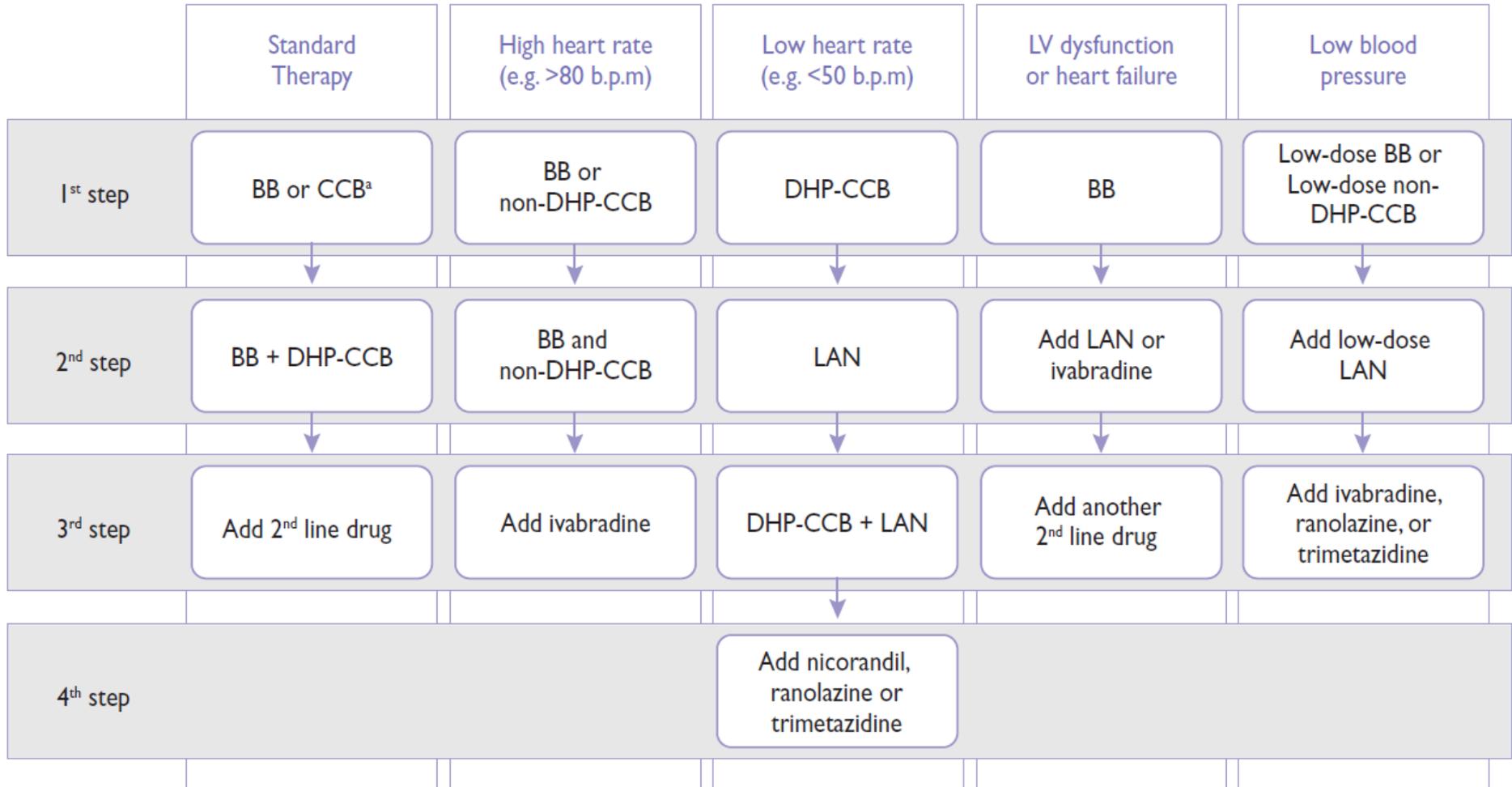
¹⁶U.O. Cardiologia, Azienda Ospedaliera Universitaria di Parma, Parma
¹⁷S.O.C. Cardiologia, Ospedale Castelli, Verbania

G Ital Cardiol 2016;17

...Angina relief therapies

(ESC point of view)...

2019 ESC Guidelines for the diagnosis and management of chronic coronary syndromes



Anti-anginal drugs—beliefs and evidence: systematic review covering 50 years of medical treatment

Ferrari R, Eur Heart J 2019

There is no evidence to support the use of first and second line treatments for the management of angina. Rather, the medical therapy of angina should be personalized

...Antithrombotic therapies...

Recommendations for event prevention		
Antithrombotic therapy in patients with CCS and in sinus rhythm		
Aspirin 75–100 mg daily is recommended in patients with a previous MI or revascularization.	I	A
Clopidogrel 75 mg daily is recommended as an alternative to aspirin in patients with aspirin intolerance.	I	B
Antithrombotic therapy post-PCI in patients with CCS and in sinus rhythm		
Aspirin 75–100 mg daily is recommended following stenting.	I	A
Clopidogrel 75 mg daily following appropriate loading (e.g. 600 mg, >5 days, or maintenance therapy) is recommended, in addition to aspirin, for 6 months following coronary stenting, irrespective of stent type, unless a shorter duration (1–3 months) is indicated due to the risk or occurrence of life-threatening bleeding.	I	A
Antithrombotic therapy in patients with CCS and AF		
When oral anticoagulation is initiated in a patient with AF who is eligible for a NOAC, a NOAC is recommended in preference to a VKA.	I	A
Long-term OAC therapy (a NOAC or VKA with time in therapeutic range >70%) is recommended in patients with AF and a CHA ₂ DS ₂ -VASc score ≥2 in males and ≥3 in females.	I	A

...ma non possiamo dimenticare che esistono pazienti candidati a...

DAPT prolongation

Dual Pathway inhibition (DPI-approach)



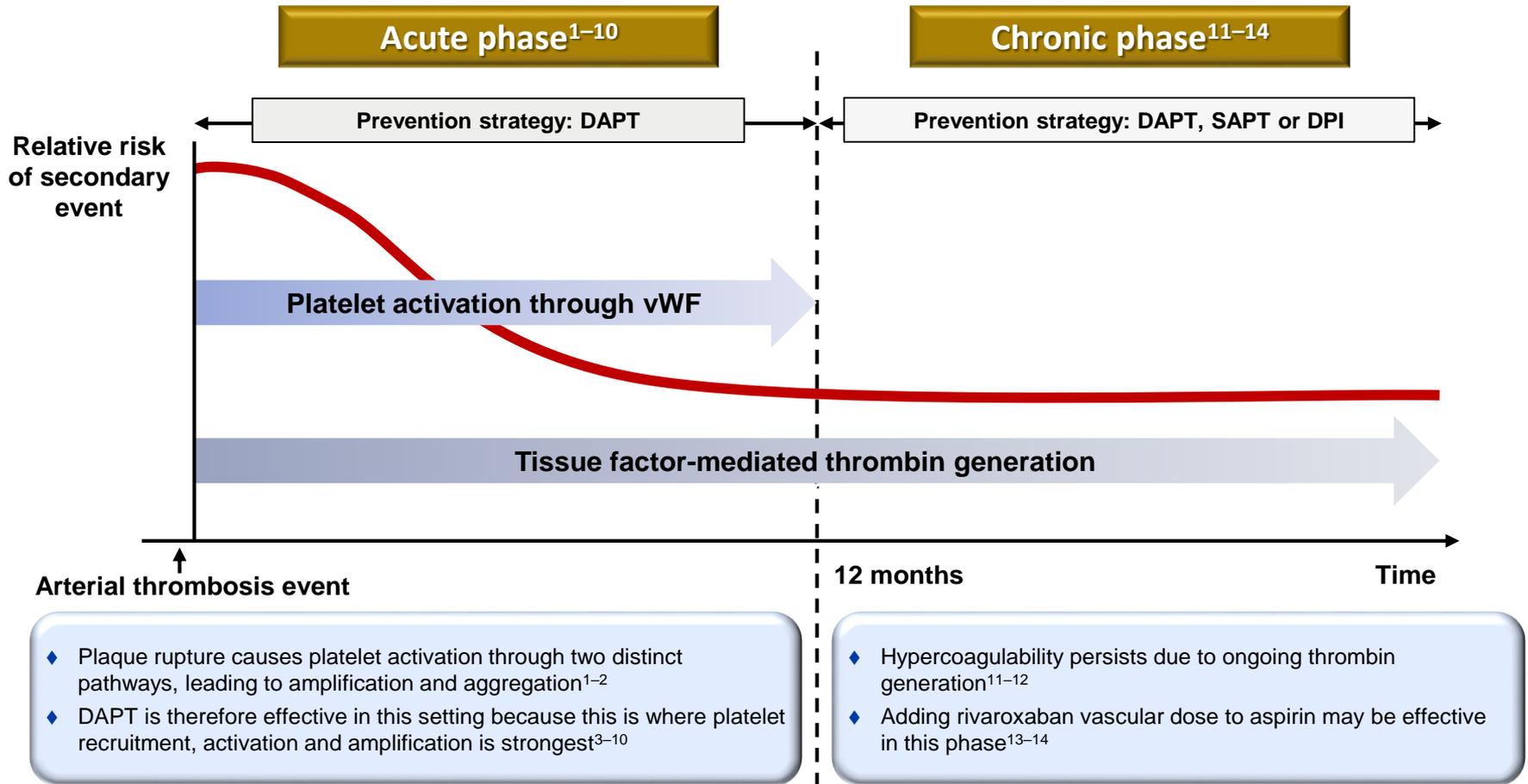
Pagando un aumentato
rischio emorragico



PEGASUS-timi 34

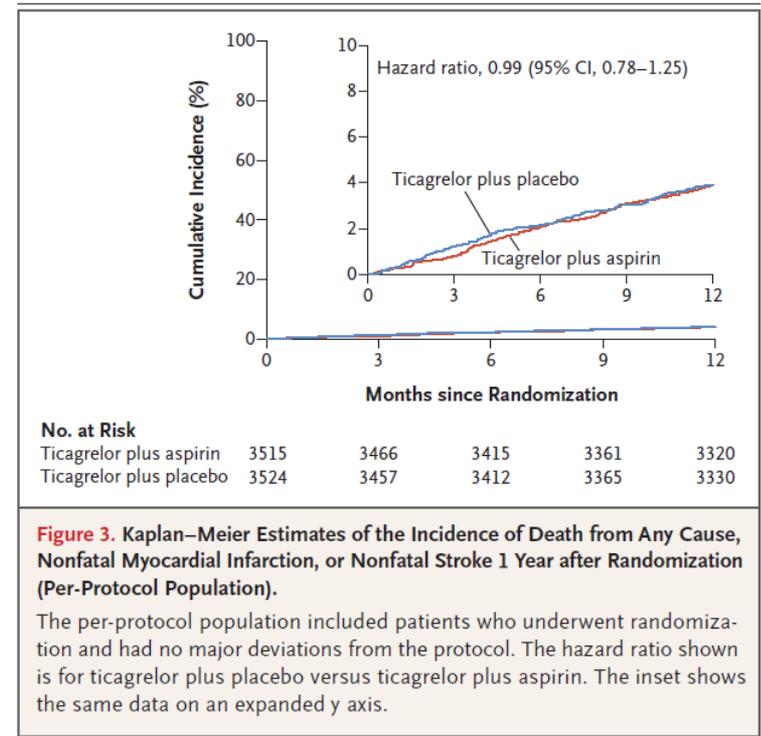
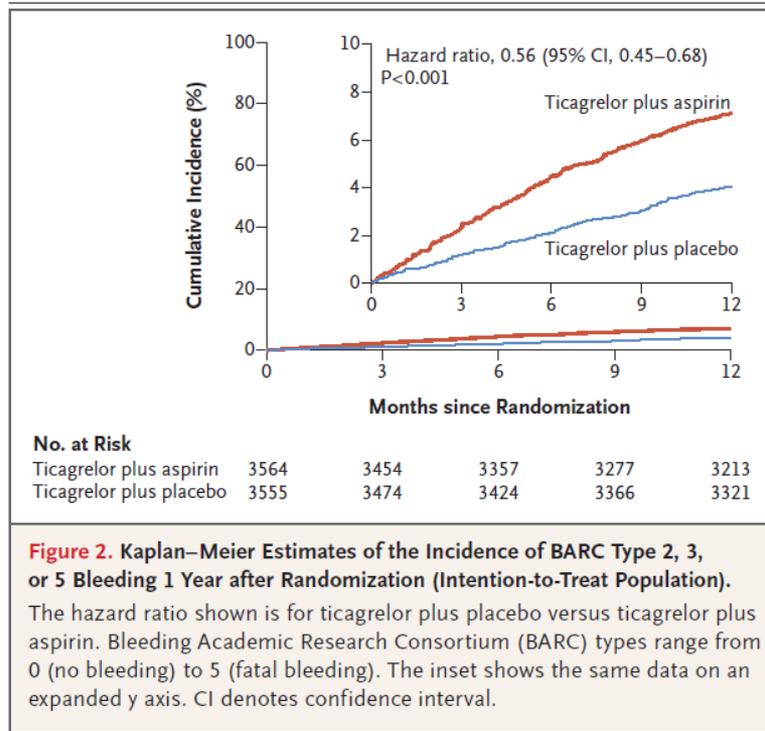
COMPASS Trial

Tailoring secondary prevention strategies to the underlying pathophysiology following an arterial thrombosis event



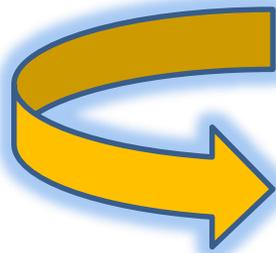
Ticagrelor with or without Aspirin in High-Risk Patients after PCI

TWILIGHT Trial



CONCLUSIONS

Among high-risk patients who underwent PCI and completed 3 months of dual antiplatelet therapy, ticagrelor monotherapy was associated with a lower incidence of clinically relevant bleeding than ticagrelor plus aspirin, with no higher risk of death, myocardial infarction, or stroke. (Funded by AstraZeneca; TWILIGHT ClinicalTrials.gov number, NCT02270242.)



Lipid-lowering drugs

Statins are recommended in all patients with CCS.

I A

If the goals are not achieved with the maximum tolerated dose of a statin, combination with ezetimibe is recommended.

I B

For patients at very high risk who do not achieve their goal on a maximum tolerated dose of statin and ezetimibe, combination with a PCSK9 inhibitor is recommended.

I A

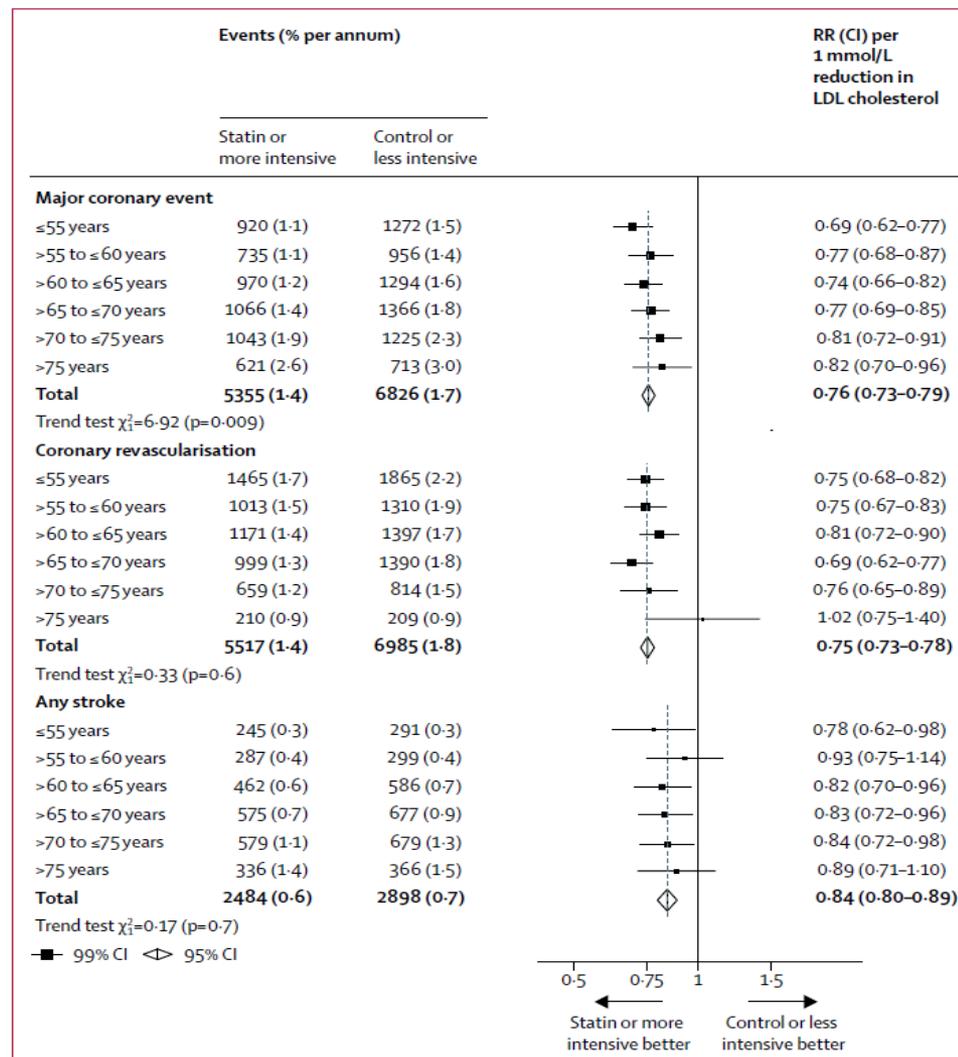
Efficacy and safety of statin therapy in older people: a meta-analysis of individual participant data from 28 randomised controlled trials



Lancet 2019; 393: 407-15

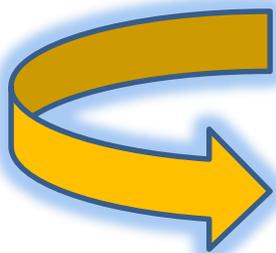
	≤75 years (n=172 321)	>75 years (n=14 483)
Age (years)	61.6 (8.0)	78.8 (2.8)
Sex		
Male	125783 (73%)	8476 (59%)
Female	46538 (27%)	6007 (41%)

...in conclusion, **statin therapy produces significant reductions in major vascular events, irrespective of age. There is less definitive direct evidence of benefit in the primary prevention setting among patients older than 75 years, but evidence supports the use of statin therapy in older people considered to have a sufficiently high risk of occlusive vascular events.**



2019 ESC Guidelines for the diagnosis and management of chronic coronary syndromes

Il consiglio per l'anziano



Recommendations for elderly patients with chronic coronary syndromes

Recommendations	Class ^a	Level ^b
It is recommended that particular attention is paid to side effects of drugs, intolerance, and overdosing in elderly patients.	I	C

Elderly patients (age >75 years) have the greatest mortality and morbidity risk attributable to CCS, which is enriched by the **high prevalence of comorbidities** (e.g. hypertension, diabetes mellitus, CKD, etc.). Although the prevalence of elderly patients with CAD is increasing, this population is usually **undertreated, underdiagnosed, and under-represented in clinical trials**. Elderly patients often present with atypical symptoms, which may delay proper diagnosis. **The treatment of CCS in the elderly is complicated by a higher vulnerability to complications** for both conservative and invasive strategies, such as bleeding, renal failure, and neurological impairments, all of which **require special attention**.

Prioritizing Functional Capacity as a Principal End Point for Therapies Oriented to Older Adults With Cardiovascular Disease

A Scientific Statement for Healthcare Professionals From the American Heart Association



SUMMARY

Older individuals now constitute the predominant population of individuals with CVD; functional impairment is a predictable consequence, particularly because CVD compounds the functional deficits associated with aging. Therefore, optimally managing these patients requires an understanding of the importance and complexities of measuring and modifying functional capacity. The consequences of functional impairment in older adults with CVD include increased morbidity and mortality and reduced ability to perform ADLs, remain independent, and delay disability. Numerous studies have documented the importance of functional capacity as a predictor of out-

comes across the spectrum of age, including the very old. Optimization of functional capacity and other measures of physical function and frailty will become even more critical as the population continues to age.

PRIMARY ENDPOINTS

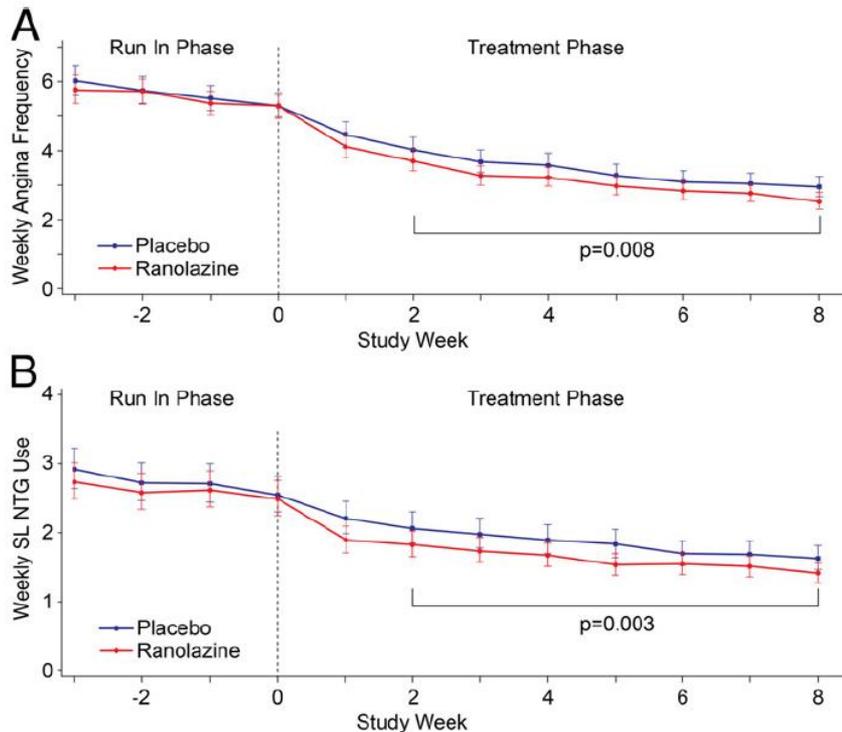
❑ FUNCTIONAL CAPACITY

❑ FRAILITY

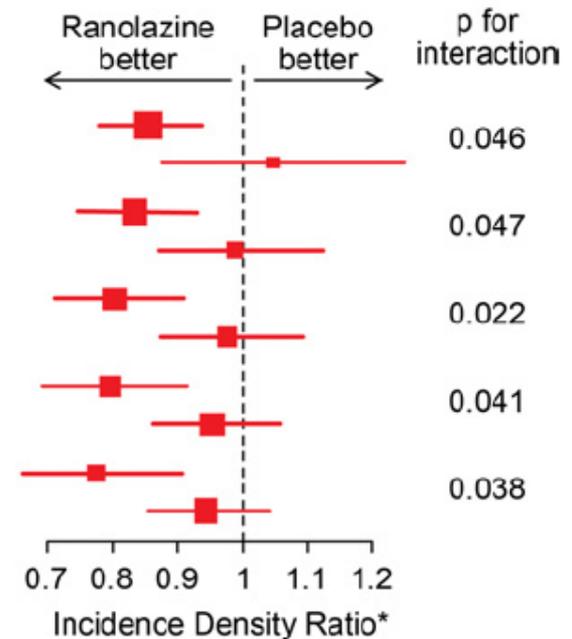
❑ DISABILITY

Evaluation of Ranolazine in Patients With Type 2 Diabetes Mellitus and Chronic Stable Angina

Results From the TERISA Randomized Clinical Trial (Type 2 Diabetes Evaluation of Ranolazine in Subjects With Chronic Stable Angina)



- HbA1c is > 6
- HbA1c is ≤ 6
- HbA1c is > 6.5
- HbA1c is ≤ 6.5
- HbA1c is > 7
- HbA1c is ≤ 7
- HbA1c is > 7.5
- HbA1c is ≤ 7.5
- HbA1c is > 8
- HbA1c is ≤ 8



Conclusions

Among patients with diabetes and chronic angina despite treatment with up to 2 agents, ranolazine reduced angina and sublingual nitroglycerin use and was well tolerated. (Type 2 Diabetes Evaluation of Ranolazine in Subjects With Chronic Stable Angina [TERISA]; NCT01425359) (J Am Coll Cardiol 2013;61:2038–45) © 2013 by the American College of Cardiology Foundation

Effects of Ranolazine on Angina and Quality of Life After Percutaneous Coronary Intervention With Incomplete Revascularization

Results From the Ranolazine for Incomplete Vessel Revascularization (RIVER-PCI) Trial

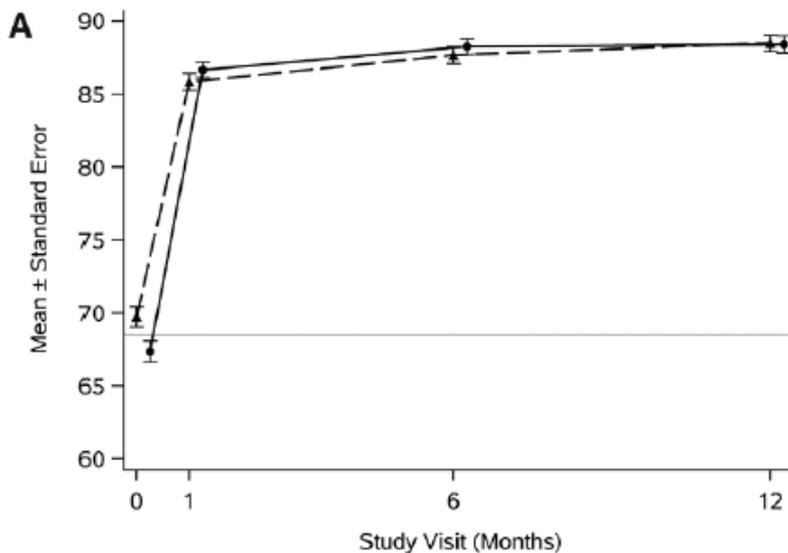


Table 3. Mean Treatment Effect* on SAQ Angina Frequency Overall and Among Subgroups

Subgroup	Ranolazine LS mean	Placebo LS Mean	LS Mean Treatment Diff (Ranolazine–Placebo; 95% CI)	P Value
Overall	87.8	86.8	1.0 (–0.2, 2.2)	0.11
Age <75 yr	87.8	86.6	1.1 (–0.1, 2.4)	0.08
Age ≥75 yr	87.7	87.9	–0.2 (–3.6, 3.3)	0.92
Men	88.0	86.8	1.2 (–0.1, 2.5)	0.07
Women	86.7	86.9	–0.2 (–2.9, 2.4)	0.87
Non-ACS PCI indication	87.6	86.3	1.2 (–0.3, 2.7)	0.11
ACS PCI indication	88.4	87.8	0.6 (–1.2, 2.5)	0.50
BL† 0–1 antianginal med‡	88.4	87.4	1.0 (–0.3, 2.4)	0.14
BL† 2–3 antianginal med‡	87.0	86.1	0.9 (–1.4, 3.2)	0.44
No diabetes mellitus	87.9	87.7	0.2 (–1.2, 1.5)	0.81
Diabetes mellitus	87.7	85.0	2.7 (0.5, 4.9)	0.02
BL† SAQ >60	86.9	86.7	0.1 (–1.1, 1.4)	0.83
BL† SAQ ≤60	88.8	86.5	2.3 (0.0, 4.6)	0.048

Conclusions—Despite ICR following PCI, there was no incremental benefit in angina or QOL measures by adding ranolazine in this angiographically-identified population. These measures markedly improved within 1 month of PCI and persisted up to 1 year in both treatment arms.

Clinical Trial Registration—URL: <http://www.clinicaltrials.gov>. Unique identifier: NCT01442038. (*Circulation*. 2016;133:39-47. DOI: 10.1161/CIRCULATIONAHA.115.019768.)

Cardiac Rehabilitation in Very Old Adults: Effect of Baseline Functional Capacity on Treatment Effectiveness

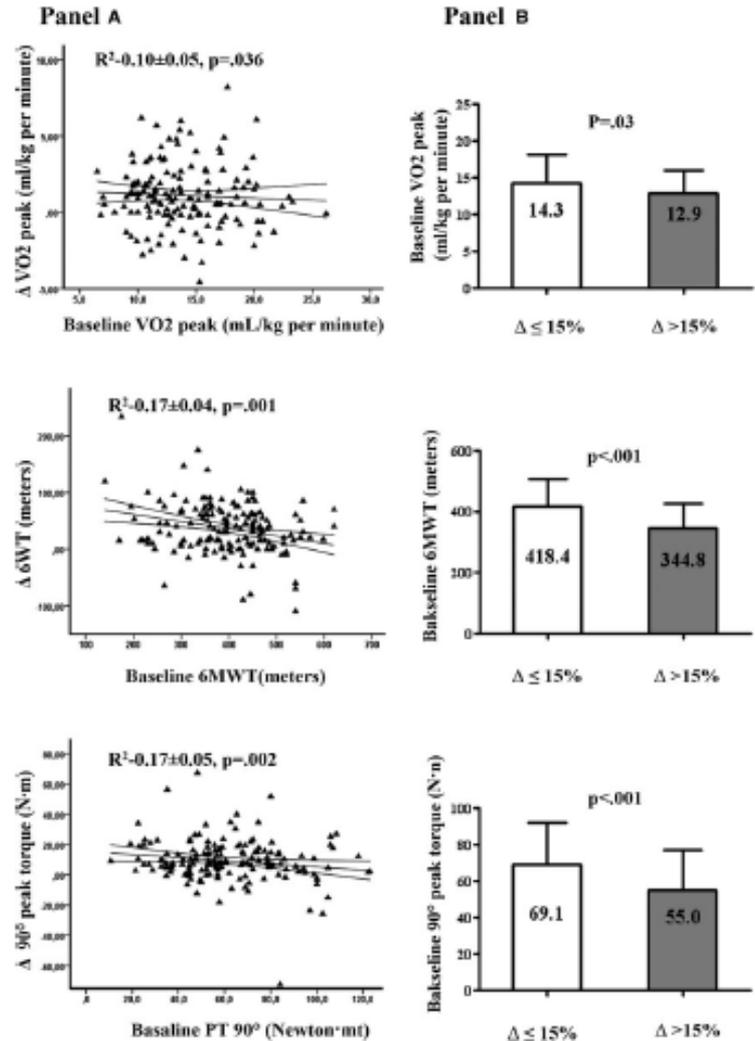
Samuele Baldasseroni, MD, PhD, Alessandra Pratesi, MD, Sara Francini, MD, Rachele Pallante, MD, Riccardo Barucci, MD, Francesco Orso, MD, Costanza Burgisser, MD, Niccolò Marchionni, MD, and Francesco Fattorioli, MD



J Am Geriatr Soc 64:1640–1645, 2016.

Conclusion

this study demonstrates that a CR program initiated soon after discharge from acute medical or surgical wards **is safe and produces improvements in exercise tolerance and muscle strength even in very old adults after an acute coronary event or cardiac surgical interventions.** Data also suggest that older adults with the greatest post-acute physical impairment are probably the most-appropriate candidates for CR incorporating physical exercise programs, from which they appear to benefit the most.



Top 10 List for the Cardiovascular Care of Older Adults

dedicarsi alla complessità

considerare la cardiopatia nel contesto

lo stato funzionale è priorità della cura

Valutare bene le LG e EBM

less may be more
(OMT vs invasive strategy può essere un
alternativa valida)

1. OLDER ADULTS ARE NOT JUST ADULTS WITH GRAY HAIR

This headline is the geriatric equivalent of the pediatric maxim, "Children are not just small adults." Aging is associated with substantial alterations in cardiovascular structure and function that influence pathophysiologic mechanisms, predispose to the development of cardiovascular disease, reduce cardiovascular reserves, and increase risk for adverse outcomes. Normal physiologic changes with aging alter safe and effective care.

2. FRAILITY IS THE VITAL SIGN OF OLD AGE

Fraility is a biological syndrome that reflects a state of decreased physiologic reserves and vulnerability to stressors. The majority of older adults are not frail, so identifying those who are is as important as detecting those who are not. Incorporate geriatric assessments as part of vital screening, as frailty, geriatric syndromes, and cognitive impairment are critical factors in older adults.

3. EMBRACE COMPLEXITY

The passage of time is associated with increasing heterogeneity across individuals of the same chronologic age. Also, symptoms pose a great masquerade in older patients—worsening hypertension, fatigue, or dizziness may be atypical presentations of typical conditions. To prepare, think broadly and critically.

4. TREAT THE CARDIAC CONDITION IN CONTEXT

Cardiovascular disease in older adults almost never occurs in isolation, so optimal management requires consideration of comorbidities.

5. WHEN IN DOUBT, ASK THE PATIENT (OR FAMILY, OR CAREGIVER)

Shared decision-making is prefaced on adequate communication and understanding. Assessing knowledge, preferences, and goals of care often requires inclusion of

6. FUNCTIONAL STATUS AND REVITALIZATION ARE KEY PRIORITIES OF CARE

Inactivity accelerates age-related declines in function. Cardiac rehabilitation, early mobilization in hospitalized patients, physical therapy and occupational therapy, outpatient rehabilitation including strengthening exercises, gait/balance, and aerobic training are vitally important to maximize function. Unfortunately, these are all under-utilized.

7. CAVEAT EMPTOR FOR THE USE OF EVIDENCE-BASED MEDICINE IN THE CARE OF OLDER ADULTS WITH CARDIOVASCULAR DISEASE

Older patients are inherently at higher risk for adverse outcomes; however, the potential benefit of an intervention is often greater. Therefore, age per se is rarely a contraindication to aggressive therapy. Yet, older patients, especially those with multiple chronic conditions, geriatric syndromes, or nursing home residence have been under-represented in cardiovascular clinical trials; therefore, the applicability of trial findings to the older population is less certain.

8. LESS MAY BE MORE

Older patients are at risk for drug side effects, complications, and iatrogenesis. Providers should consider unprescribing, practice slow medicine, and allow time to determine need for interventions when feasible.

9. WHILE YOU CAN'T ALWAYS CURE, DON'T EVER ABANDON

Every technology is built for a purpose. Invasive procedures (eg, coronary artery bypass grafting, implantable coronary defibrillator, destination left ventricular assist devices, and transcatheter aortic valve replacement) should be undertaken for clearly defined and attainable goals of care. When a procedure or intervention is deemed unnecessary or futile, optimal care can and should continue.

10. PALLIATIVE CARE AND END-OF-LIFE DISCUSSIONS SHOULD BE IN THE TOOLBOX FOR CARE

Death is a certainty, yet a good death is often hard to come by. The best care considers quality of death and quality of life. Not all patients are able to discuss these issues, but avoiding the conversation risks missing an opportunity to provide better care. Palliative care can be helpful for all patients who need to choose among potentially complicated health care options. Helping patients, families, and



**- Dean Smith –
The Coaches' Coach**

“Play Hard and Play Together.”