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SOCIETÀ ITALIANA
DI GERONTOLOGIA
E GERIATRIA

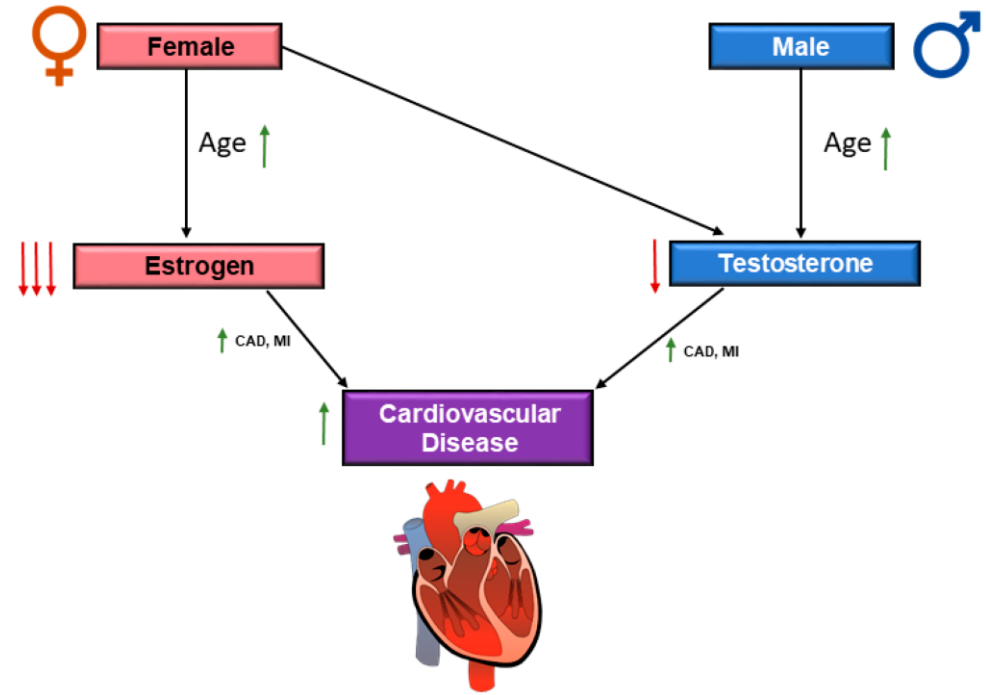
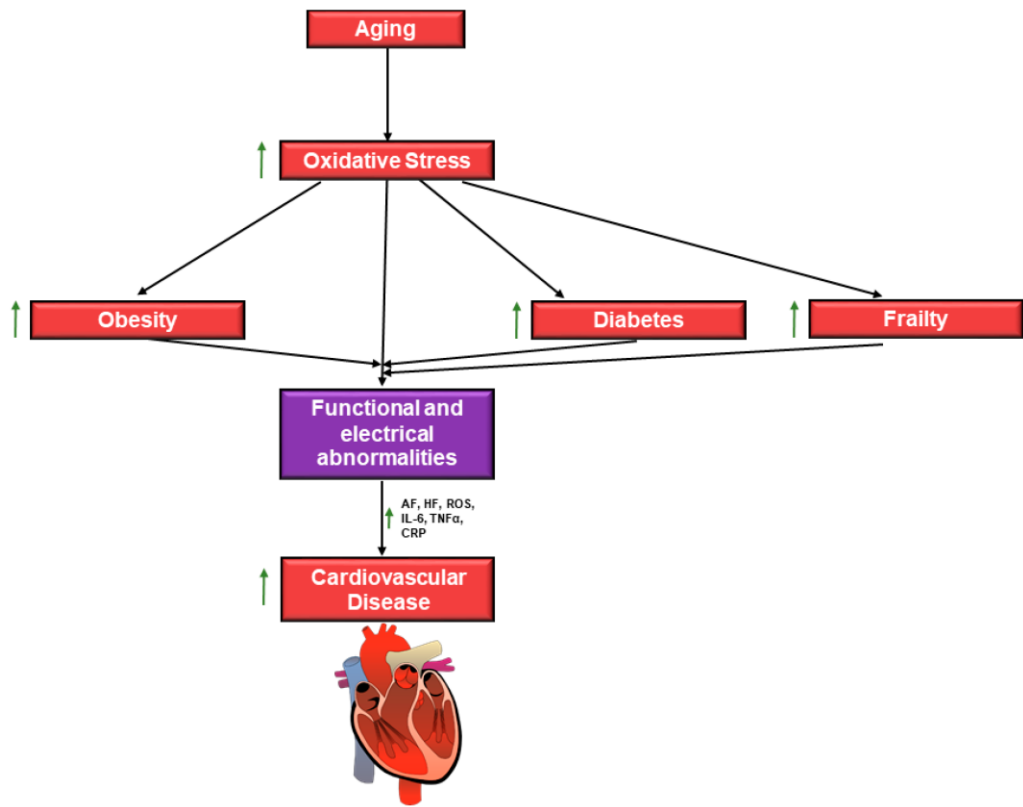
Cardiologia Geriatrica

Dott.ssa Erika Parente
A.O.U. Federico II



What to Expect From the Evolving Field of Geriatric Cardiology

Geriatric cardiology melds cardiovascular perspectives with multimorbidity, polypharmacy, frailty, cognitive decline, and other clinical, social, financial, and psychological dimensions of aging. Although some assume that a cardiologist may instinctively cultivate some of these skills over the course of a career, we assert that the volume and complexity of older cardiovascular patients in contemporary practice warrants a more direct approach to achieve suitable training and a more reliable process of care.



The incidence of cardiovascular disease (CVD) increases with age

- **40%** in adults aged 40–59 years
- **75%** in those 60–79 years
- **86%** in those >80 years

COMMENTARY

Age and Ageing journal 50th anniversary commentary series

Clinical trials in older people

KAISU H. PITKALA¹, TIMO E. STRANDBERG²

Despite the fact that older people use the largest share of all medications, they have been clearly **underrepresented** in clinical trials

This problem has concerned treatments for cancer, **cardiovascular disease** and many other illnesses

One recent example was COVID-19 vaccine trials, in which only 1.7% of the study populations were 75+ years, whereas they were the first age group that had to be vaccinated

Clinical trials in older people

KAISU H. PITKALA¹, TIMO E. STRANDBERG²

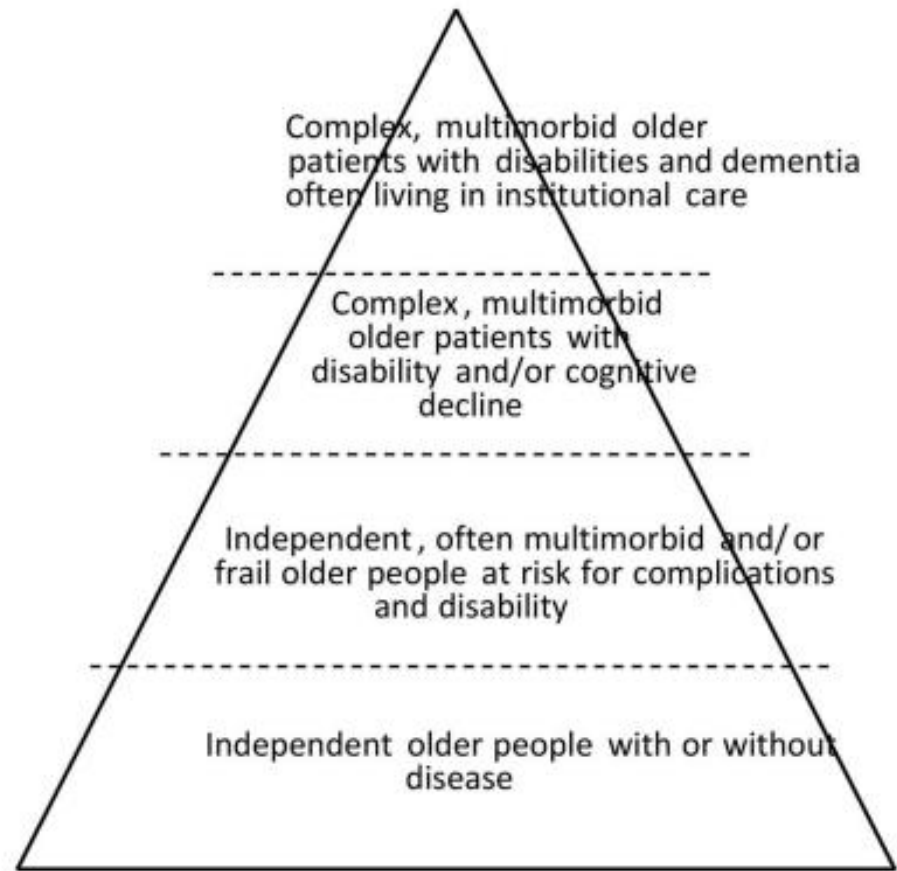


Figure 1. Older people in clinical trials are heterogeneous. The trial target group should be described in detail. This triangle may roughly help describe the target population.

Frailty in cardiology: definition, assessment and clinical implications for general cardiology. A consensus document of the Council for Cardiology Practice (CCP), Association for Acute Cardio Vascular Care (ACVC), Association of Cardiovascular Nursing and Allied Professions (ACNAP), European Association of Preventive Cardiology (EAPC), European Heart Rhythm Association (EHRA), Council on Valvular Heart Diseases (VHD), Council on Hypertension (CHT), Council of Cardio-Oncology (CCO), Working Group (WG) Aorta and Peripheral Vascular Diseases, WG e-Cardiology, WG Thrombosis, of the European Society of Cardiology, European Primary Care Cardiology Society (EPCCS)

Dimitri Richter^{1†}, Luigina Guasti^{2*†}, David Walker³, Ekaterini Lambrinou⁴, Christos Lionis⁵, Ana Abreu^{6,7}, Irina Savelieva⁸, Stefano Fumagalli⁹, Mario Bo¹⁰, Bianca Rocca¹¹, Magnús T. Jensen¹², Luc Pierard¹³, Isabella Sudano¹⁴, Victor Aboyans¹⁵, and Riccardo Asteggiano^{2,16}

¹Euroclinic Hospital, Athens, Greece; ²Internal Medicine, Department of Medicine and Surgery, University of Insubria, ASST-settelaghi, Via Galicciardini 5, 21100 Varese, Italy; ³East Sussex Healthcare NHS Trust, Hastings, UK; ⁴Department of Nursing, School of Health Sciences Cyprus University of Technology Limassol, Limassol, Cyprus; ⁵Clinic of

Box 1. Definitions.

FRAILITY:

Multidimensional and multisystem condition characterized by decreased functional reserves and increased vulnerability to stress and acute adverse events.

This condition, a complex system behavior of components, can be described according to:

- peculiar genesis, including accumulation of damages and dysregulations,
- peculiar phenotype including physical, nutritional, cognitive/psychological and social aspects, and
- adverse health-related outcomes

MULTIMORBIDITY:

Concurrent presence of two or more medically diagnosed diseases in the same individual, closely related with ageing

DISABILITY:

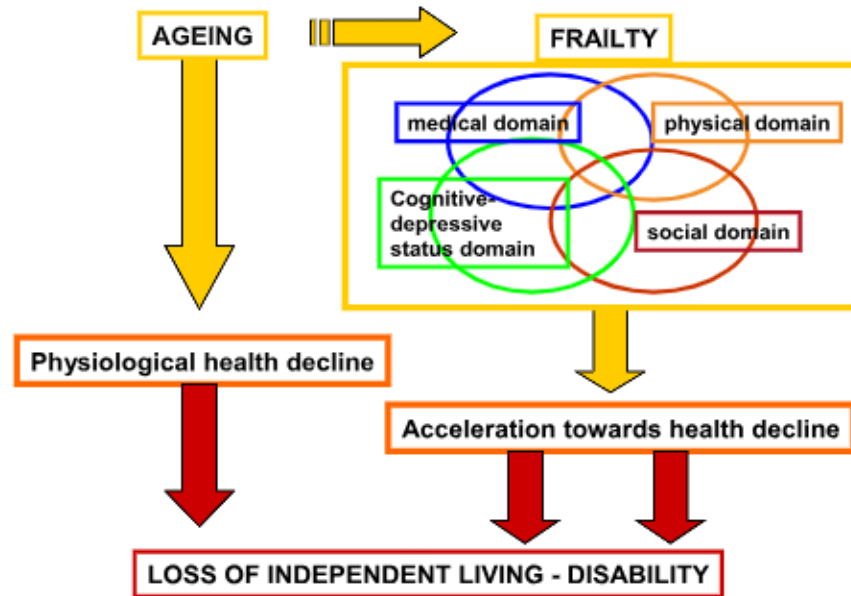
Difficulty or dependency in carrying out activities essential for daily living, including tasks needed for self-care and living independently

OVERLAPPING CONDITIONS:

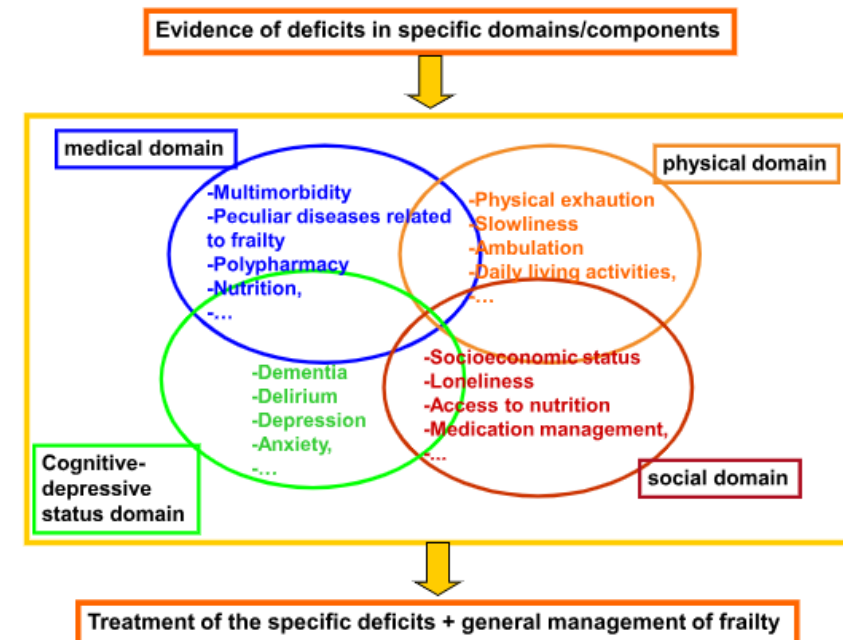
Ageing is associated with frailty, multimorbidity and disability and the three conditions are largely overlapping.

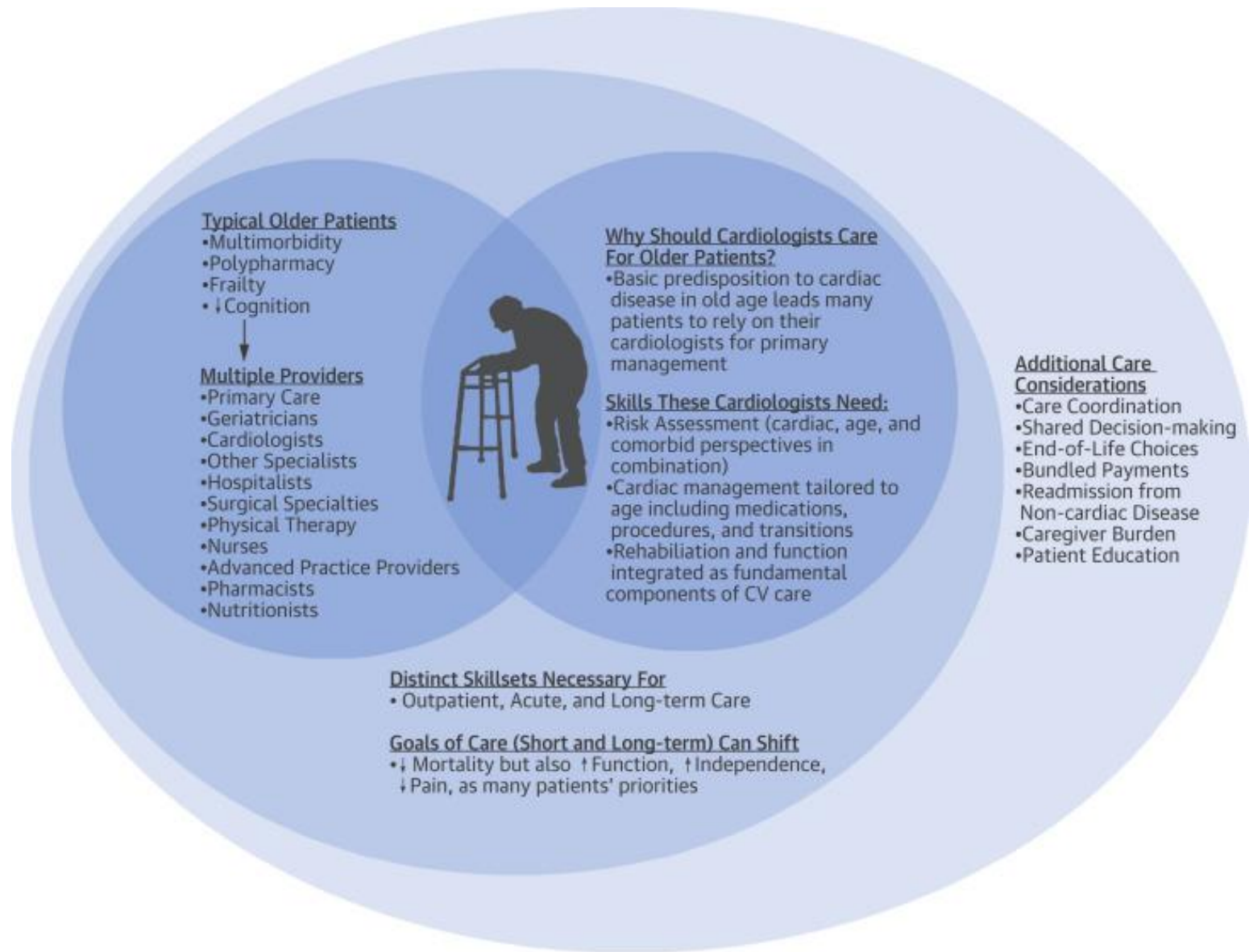
Digital health in older adults for the prevention and management of cardiovascular diseases and frailty.
A clinical consensus statement from the ESC Council for Cardiology Practice/Taskforce on Geriatric Cardiology, the ESC Digital Health Committee and the ESC Working Group on e-Cardiology

(A) Ageing and frailty-related health decline



(B) Frailty domains and components





Evaluation of frailty

Table 1. Operationalizing a Phenotype of Frailty

A. Characteristics of Frailty	B. Cardiovascular Health Study Measure*
Shrinking: Weight loss (unintentional) Sarcopenia (loss of muscle mass)	Baseline: >10 lbs lost unintentionally in prior year
Weakness	Grip strength: lowest 20% (by gender, body mass index)
Poor endurance; Exhaustion	“Exhaustion” (self-report)
Slowness	Walking time/15 feet: slowest 20% (by gender, height)
Low activity	Kcals/week: lowest 20% males: <383 Kcals/week females: <270 Kcals/week
	C. Presence of Frailty
	Positive for frailty phenotype: ≥ 3 criteria present
	Intermediate or prefrail: 1 or 2 criteria present

*See Appendix.

Clinical Frailty Scale*



1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.



2 Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.



3 Managing Well – People whose **medical problems are well controlled**, but are **not regularly active** beyond routine walking.



4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being “slowed up”, and/or being tired during the day.



5 Mildly Frail – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.



6 Moderately Frail – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.



7 Severely Frail – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).



8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.



9. Terminally Ill - Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise evidently frail**.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

PHYSICAL FRAILTY: ICFSR INTERNATIONAL CLINICAL PRACTICE GUIDELINES FOR IDENTIFICATION AND MANAGEMENT

E. DENT^{1,2}, J.E. MORLEY³, A.J. CRUZ-JENTOFT⁴, L. WOODHOUSE⁵, L. RODRÍGUEZ-MAÑAS⁶, L.P. FRIED⁷, J. WOO⁸, I. APRAHAMIAN⁹, A. SANFORD³, J. LUNDY¹⁰, F. LANDI¹¹, J. BELBY¹, F.C. MARTIN¹², J.M. BAUER¹³, L. FERRUCCI¹⁴, R.A. MERCHANT¹⁵, B. DONG¹⁶, H. ARAI¹⁷, E.O. HOOGENDIJK¹⁸, C.W. WON¹⁹, A. ABBATECOLA²⁰, T. CEDERHOLM²¹, T. STRANDBERG^{22,23}, L.M. GUTIÉRREZ ROBLEDO²⁴, L. FLICKER²⁵, S. BHASIN²⁶, M. AUBERTIN-LEHEUDRE²⁷, H.A. BISCHOFF-FERRARI²⁸, J.M. GURALNIK²⁹, J. MUSCEDERE³⁰, M. PAHOR³¹, J. RUIZ³², A.M. NEGM³³, J.Y. REGINSTER³⁴, D.L. WATERS³⁵, B. VELLAS³⁶

Frailty Screening

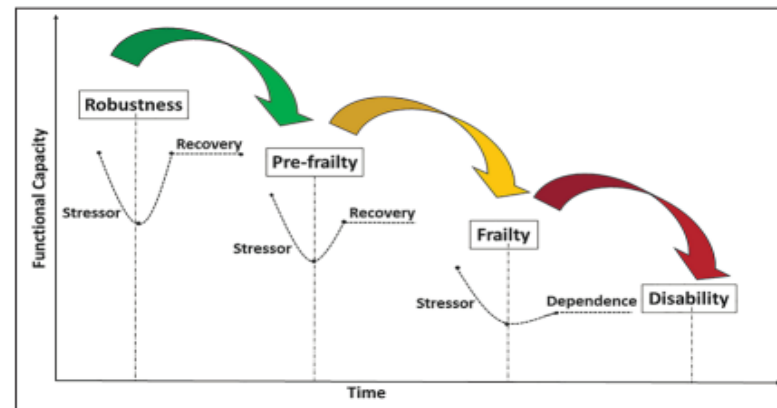
Recommendation 1: All adults aged 65 years and over should be offered opportunistic screening for frailty using a simple, validated frailty instrument suitable to the specific setting or context (Strong recommendation; low certainty of evidence)

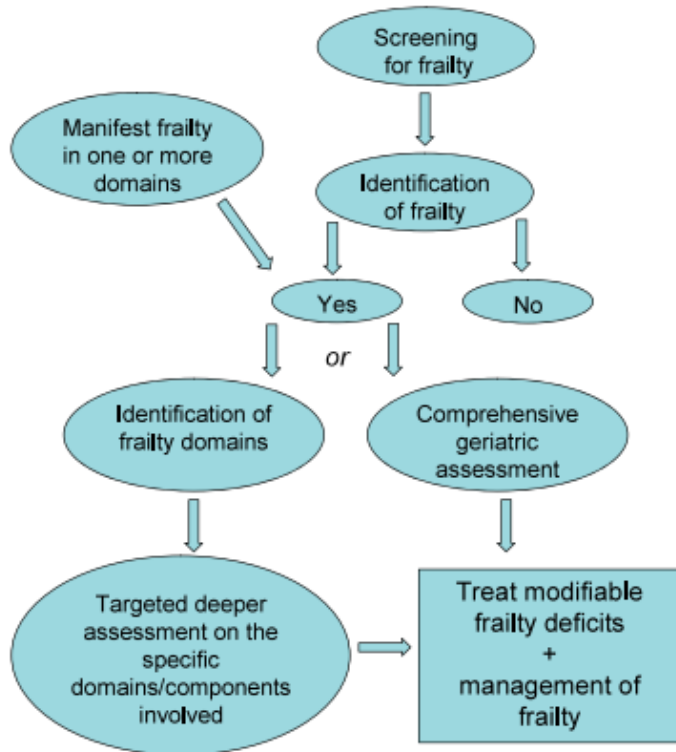
Physical Frailty Assessment

Recommendation 2: Clinical assessment of frailty should be performed for all older adults screening as positive for frailty or pre-frailty (Strong recommendation; low certainty of evidence)

Development of a Comprehensive Management Plan

Recommendation 3: A comprehensive care plan for frailty should systematically address: polypharmacy, the management of sarcopenia, treatable causes of weight loss, and the causes of exhaustion (depression, anaemia, hypotension, hypothyroidism, and vitamin B12 deficiency) (Strong recommendation; very low certainty of evidence)





Frailty evaluation

If the presence of frailty is identified after screening, or the patient is presenting a manifest form of frailty, a more detailed assessment of the specific deficit evidenced or a comprehensive geriatric assessment is indicated. It is a crucial step to recognize the frailty domains, their components and their relative weight in order to give a tailored personalized response to the patients' peculiar needs.

Frailty screening tools should be sensitive, specific, quick to administer, validated for screening, and not requiring specific equipment

Table 1 Initial evaluation of Frailty in CV disease

Instrument	Frailty domain	Components	Test	Score
5-m gait speed test	Physical function	Slowliness	Patient is positioned behind start line and asked to walk at a comfortable pace past 5-m finish line; cue to trigger stopwatch is first footfall after start line and first footfall after finish line; average of three times	Slow: <0.83 m/s (>6s) Very slow: <0.65 m/s (>7.7 s) Extremely slow: <0.50 m/s (>10 s)
Handgrip strength test	Physical function	Weakness	Patient is asked to squeeze a handgrip dynamometer as hard as possible; repeated three times (once with each hand and then with strongest hand); maximum value is recorded	Men: <30 kg Women: <20 kg
Physical activity questionnaire	Physical function		Many questionnaires have been validated; some provide a measure of activity in kcal/week (e.g. Minnesota Leisure Time Activity, PASE, Paffenbarger Physical Activity Questionnaire)	Men: <383 kcal/week Women: <270 kcal/week
CES-D questionnaire	Physical function	Exhaustion	Two questions administered: How often in the past week did you feel like everything you did was an effort/like you could not get going? [often (i.e. ≥3 days) or not often (i.e. 0–2 days)]	Positive if often is the answer to either question
Short Physical Performance Battery	Physical function	Three-Items Balance Weakness (chair rise) Gate (5 min gate)	Balance: Patient is asked to stand in semi-tandem position for 10 s; if patient is able, then he/she is asked to stand in full tandem position for 10 s; if patient is not able, then he/she is asked to stand in side-by-side position for 10 s Chair rise: Patient is seated on a straight-backed chair and asked to stand up five times as quickly as possible without using arms; time to complete five sit-to stand repetitions is recorded 5-min gate speed: See above	Balance 0 = side by side 0–9 s or unable 1 = side by side 10 s 2 = full tandem 0–2 s 3 = full tandem 3–9 s 4 = full tandem 10 s Chair rise: 0 = unable 1 = ≥16.7 s 2 = 13.7–16.6 s 3 = 11.2–13.6 s 4 = ≤11.1 s 5-min gate speed: As above Composite score Each item is scored 0–4 Frail if composite score ≤5/12
Weight loss	Medical domain	Nutritional status Shrinking	Self-reported or measured unintentional weight loss	≥10 lbs (≥4.54 kg) in past year
Serum albumin	Medical domain	Nutritional status Shrinking	Laboratory measured serum albumine	<3.5 g/dL
Serum Hb	Medical domain	Nutritional status Multisystem proxy	Laboratory measured serum haemoglobin	<13 g/dL man <12 g/dL women

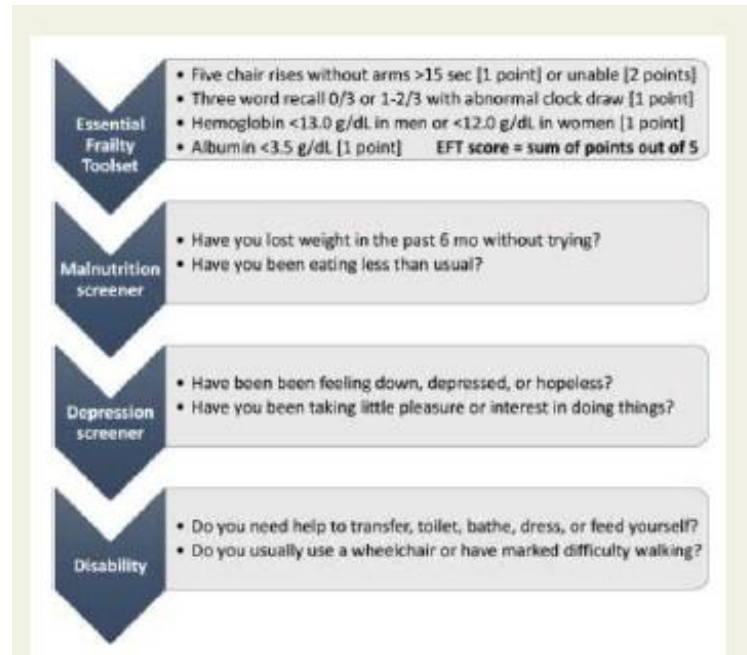
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Table 1 Continued




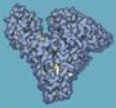
Instrument	Frailty domain	Components	Test	Score
Electronic medical record	Medical domain and mind and emotion	Comorbidities Polypharmacy Sensory impairment Depression anxiety	Non applicable	Non applicable
Fried frailty index	Medical domain and physical function	Slowness, weakness, low physical activity, exhaustion, and shrinking	See Table 1a5 and 1b5 Supplemental materials	See Supplemental materials
Clinical frailty scale	Medical domain	Semiquantitative (generic)	See Figure 1S Supplemental material	See Supplemental materials
Essential frailty toolset	Multidomain	Multiple components (four-items): Weakness Cognitive Nutritional status Multisystem proxy	See Figure 2 Supplemental material Four-item test: chair stands, cognitive impairment or recall three out of three words after a distractive task), measured lab serum haemoglobin, and serum albumin	The tool is scored 0 (least frail) to 5 (most frail) Chair: ≥15 s or inability to complete five sit-to-stand repetitions without using arms Cognitive: score of <24 on the Mini-Mental State Examination (which is highly unlikely if the patient is able to correctly recall three out of three words after a distractive task and may obviate the need for further cognitive testing) Lab (see above)

...in order to give a *tailored personalized response* to the patients' peculiar needs...

Short multidomain screening



CENTRAL ILLUSTRATION: Essential Frailty Toolset in Older Adults Undergoing Aortic Valve Replacement

	Five chair rises <15 seconds	0 Points
	Five chair rises ≥15 seconds	1 Point
	Unable to complete	2 Points
	No cognitive impairment	0 Points
	Cognitive impairment	1 Point
	Hemoglobin ≥13.0 g/dL ♂ ≥12.0 g/dL ♀	0 Points
	Hemoglobin <13.0 g/dL ♂ <12.0 g/dL ♀	1 Point
	Serum albumin ≥3.5 g/dL	0 Points
	Serum albumin <3.5 g/dL	1 Point

EFT Score	1-Year Mortality TAVR	SAVR
0-1	6%	3%
2	15%	7%
3	28%	16%
4	30%	38%
5	65%	50%




EFT Points: _____

Afilalo, J. et al. J Am Coll Cardiol. 2017;70(6):689-700.

Proposed as minimum screening in patients considered for transcatheter aortic valve replacement including the Essential Frailty Toolset, malnutrition, depression and disability screening

ORIGINAL RESEARCH

The Essential Frailty Toolset in Older Adults Undergoing Coronary Artery Bypass Surgery

Joshua Solomon, MD, MSc ; Emmanuel Moss, MD; Jean-Francois Morin, MD; Yves Langlois, MD; Renzo Cecere, MD; Benoit de Varennes, MD; Kevin Lachapelle, MD; Nicolo Piazza, MD, PhD; Giuseppe Martucci, MD; Melissa Bendayan, MSc; Palina Piankova, MSc; Victoria Hayman, BSc ; Marie-Claude Ouimet, BSc; Lawrence G. Rudski, MD; Jonathan Afilalo, MD, MSc 

ORIGINAL RESEARCH

Comparison of Questionnaire and Performance-Based Physical Frailty Scales to Predict Survival and Health-Related Quality of Life in Patients With Heart Failure

Joseph Somech ^{ID}, MD; Aayushi Joshi ^{ID}, MSc; Rita Mancini, MSc; Jessica Chetrit ^{ID}, MSc; Caroline Michel, MD; Richard Sheppard, MD; Viviane Nguyen ^{ID}, MD, MSc; Mathieu Walker ^{ID}, MD; Nadia Giannetti ^{ID}, MD; Abhinav Sharma ^{ID}, MD, MPH; Delina Maghakian, RN; Esther Laforest ^{ID}, RN, MSc; Jonathan Afilalo ^{ID}, MD, MSc

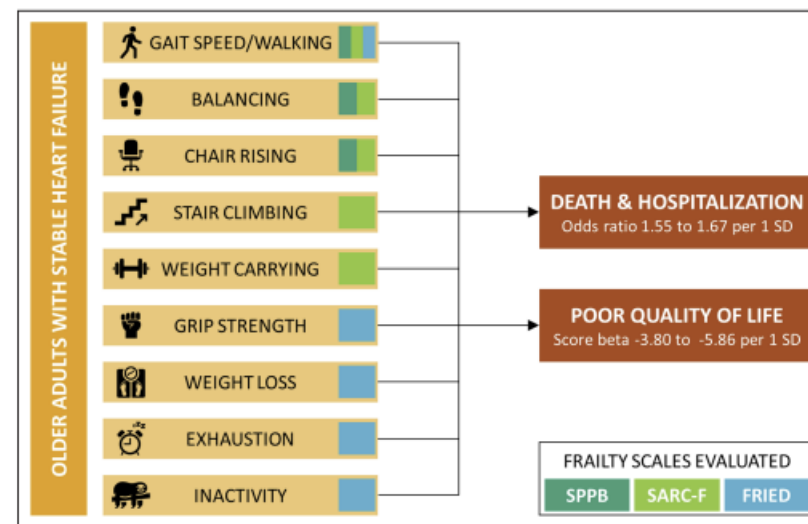


Figure 2. Prognostic value of physical frailty in older patients with heart failure.
The SPPB, SARC-F, and Fried scales represent interrelated domains of physical frailty that were collectively found to be associated with death, hospitalization, and reduced health-related quality of life. SARC-F indicates strength, assistance with walking, rising from a chair, climbing stairs, and falls; and SPPB, Short Physical Performance Battery.

Table 3. Prediction of Death or Hospitalization at 3 Months

Frailty scale	Standardized adjusted OR (95% CI)	P value	Change in AUC	Change in BIC
SPPB	1.67 (1.09–2.55)	0.02	0.021	-0.3
Fried	1.60 (1.04–2.46)	0.03	0.015	0.1
SARC-F	1.55 (1.03–2.35)	0.04	0.013	1.0

Multivariable logistic regression models were adjusted for age, sex, and Meta-Analysis Global Group in Chronic Heart Failure score. Improved discrimination is indicated by positive values of ΔC statistic and negative values of ΔBIC . AUC indicates area under receiver operating characteristic curve; BIC, Bayesian information criterion; OR, odds ratio; SARC-F, strength, assistance with walking, rising from a chair, climbing stairs, and falls; and SPPB, Short Physical Performance Battery.

Which frailty tool best predicts morbidity and mortality in ambulatory patients with heart failure? A prospective study

Shirley Sze^{1,2,*}, Pierpaolo Pellicori^{1,3}, Jufen Zhang^{1,4}, Joan Weston¹ and Andrew L. Clark¹

¹Department of Cardiology, Castle Hill Hospital, Hull York Medical School (at University of Hull), Kingston upon Hull, HU16 5JQ, UK; ²Cardiovascular Research Centre, University of Leicester, Glenfield Hospital, Groby Road, Leicester, LE3 9QP, UK; ³Robertson Centre for Biostatistics & Clinical Trials, University of Glasgow, Glasgow, G12 8QQ, UK; and ⁴Faculty of Medical Science, Anglia Ruskin University, Cambridge, CB1 1PT, UK

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Table 3 Addition of frailty tools and its impact on performance of base model in predicting all-cause mortality and the combined outcome at 1 year¹

Model	All-cause mortality		Combined outcome	
	C-statistics	Likelihood ratio test Compared with base model (P value)	C-statistics	Likelihood ratio test Compared with base model (P value)
Base model*	0.752	–	0.682	–
Screening tools				
Base* + CFS	0.835	<0.001	0.734	<0.001
Base* + AFN	0.788	<0.001	0.726	<0.001
Base* + DFI	0.780	0.004	0.719	<0.001
Assessment tools				
Base* + Fried criteria	0.812	<0.001	0.729	<0.001
Base* + DI	0.826	<0.001	0.739	<0.001
Base* + EFS	0.820	<0.001	0.747	<0.001
Single tests				
Base* + 5MWT	0.795	<0.001	0.703	<0.001
Base* + TUGT	0.787	<0.001	0.732	<0.001
Base* + Grip strength	0.783	<0.001	0.715	<0.001

AF, atrial fibrillation; SR, sinus rhythm; NYHA, New York Heart Association; NT-proBNP, N-terminal pro-B-type natriuretic peptide; Na, sodium; CFS, clinical frailty scale; DFI, Derby frailty index; AFN, Acute frailty network frailty criteria; DI, Deficit index; EFS, Edmonton frailty scale; 5MWT, 5 meter walk test; TUGT, Timed get up and go test.

¹ Harrell's C-statistic was used to evaluate model discrimination in survival analyses. The likelihood ratio test was used to determine if there was any significant difference in model fit between the base model and models including different frailty tools.

*Base model: NYHA (III/IV vs. I/II), Log [NT-proBNP], Rhythm (AF vs. SR), Na.



Cardiovascular disease in the elderly: proceedings of the European Society of Cardiology—Cardiovascular Round Table

Maddalena Lettino ^{1*}, Julia Mascherbauer ², Matias Nordaby ³, André Ziegler ⁴, Jean-Philippe Collet ⁵, Geneviève Derumeaux ^{6,7}, Stefan H. Hohnloser ^{8,9}, Christophe Leclercq ¹⁰, Deirdre E. O’Neill ^{11,12}, Frank Visseren ¹³, Franz Weidinger ¹⁴, and Isabelle Richard-Lordereau ¹⁵

Table 1 Summary of important clinical trials of primary prevention strategies in older people

Risk factor/interventions	Clinical trials	Findings
Hypertension	SHEP, ²⁰ Syst-Eur, ²¹ HYVET, ²² SPRINT ^{23,24} Intensive SBP targets could prevent ~107 500 deaths/years, at the expense of episodes of hypotension (~56 000), syncope (~34 000), serious electrolyte disturbances (~43 000), and acute kidney injury (~88 000) ²⁴	<ul style="list-style-type: none"> • Proven benefit in older people (fit and frail).^{25,26} Maximum benefits in >75–80 years.²⁶ • Benefits of antihypertensive therapy need to be weighed with risks; increased susceptibility to adverse events in older adults • Treatment targets need to be individualized based on function, frailty, independence to minimize harms^{27,28}
Dyslipidaemia	Age >65 years: meta-analyses suggest benefits ^{29,30} Limited data >75 years: PROSPER (age 70–82 years), benefits driven by secondary prevention benefit ³¹	<ul style="list-style-type: none"> • Statins appropriate for most healthy older people for prevention of MI/stroke, less evidence of mortality benefit^{29,30} • Consider longer time-to-benefit with statins (~2–2.5 years), as well as patient’s anticipated life expectancy^{32,33} • Older people more susceptible to adverse events, and more likely to have co-existing frailty, sarcopenia, polypharmacy; all of which increase potential for harm if adverse effect occurs; thus risk assessment and shared decision making are essential¹⁴
Type 2 diabetes mellitus	Metformin: e.g. UKPDS ³⁴ SGLT-2 inhibitors: EMPA-REG OUTCOME, ³⁵ DECLARE TIMI-58 ³⁶ GLP-1 receptor agonists: SUSTAIN 6, ³⁷ REWIND, ³⁸ LEADER ³⁹	<ul style="list-style-type: none"> • Metformin, SGLT-2 inhibitors, and GLP-1 are recommended for older people for prevention of events⁴⁰ • Intensive glycaemic control not shown to reduce mortality⁴⁰ • Tailor targets to individual patient—based on function, frailty, life expectancy⁴⁰
Aspirin	ARRIVE, ⁴¹ ASCEND, ⁴² ASPREE ^{43,44}	<ul style="list-style-type: none"> • Minimal or no net clinical benefit in older people (risk of bleeding vs. MACE/mortality)^{41–43} • Not recommended for primary prevention^{14,45,46} • Beers Criteria recommends additional caution when using ASA in older adults, due to risk of bleeding⁴⁵
Smoking	Meta-analyses ^{47,48}	<ul style="list-style-type: none"> • CV risks decreased with time since cessation becoming significant within <5 years, and reach non-smoker level at ~20 years^{47,48} • Cessation is important at any age¹⁴
Diet	PREDIMED, ⁴⁹ EPIC ⁵⁰ Meta-analyses and RCTs suggest no benefit for vitamin C, D, or E Meta-analyses for omega-3 fatty acids conflicting	<ul style="list-style-type: none"> • Mediterranean diet reduced risk of MACE • No apparent benefit of vitamin supplements • Omega-3 fatty acids, particularly EPO may be considered
Exercise	Honolulu Heart Program, ⁵¹ Zutphen Elderly Study ⁵²	<ul style="list-style-type: none"> • Reduction in CVD risk^{14,51–53} • Tailor to individual’s needs and ability^{14,53}

Abbreviations for trials can be found in the references.
CVD, cardiovascular disease; EPO, eicosapentaenoic acid; MACE, major cardiovascular events; SBP, systolic blood pressure.

2024 ESC Guidelines for the management of elevated blood pressure and hypertension

Developed by the task force on the management of elevated blood pressure and hypertension of the European Society of Cardiology (ESC) and endorsed by the European Society of Endocrinology (ESE) and the European Stroke Organisation (ESO)

Older and frail patients		
It is recommended that treatment of elevated BP and hypertension among older patients aged <85 years who are not moderately to severely frail follows the same guidelines as for younger people, provided BP-lowering treatment is well tolerated.	I	A
When initiating BP-lowering treatment for patients aged ≥85 years, and/or with moderate-to-severe frailty (at any age), long-acting dihydropyridine CCBs or RAS inhibitors should be considered, followed, if necessary, by a low-dose diuretic if tolerated, but preferably not a beta-blocker (unless compelling indications exist) or an alpha-blocker.	IIa	B
As the safety and efficacy of BP treatment is less certain in individuals with moderate or severe frailty, clinicians should consider screening older adults for frailty using validated clinical tests; frail patients' health priorities and a shared-decision approach should be considered when deciding on BP treatments and targets.	IIa	C
If BP drops with progressing frailty, deprescription of BP-lowering medications (and other drugs that can reduce BP, such as sedatives and prostate-specific alpha-blockers) may be considered.	IIb	C
Hypertension and orthostatic hypotension		
Before starting or intensifying BP-lowering medication, it is recommended to test for orthostatic hypotension, by first having the patient sit or lie for 5 min and then measuring BP 1 and/or 3 min after standing.	I	B
It is recommended to pursue non-pharmacological approaches as the first-line treatment of orthostatic hypotension among persons with supine hypertension. For such patients, it is also recommended to switch BP-lowering medications that worsen orthostatic hypotension to an alternative BP-lowering therapy and not to simply de-intensify therapy.	I	A

In older patients (aged ≥65 years) receiving BP-lowering drugs:

- It is recommended that systolic BP should be targeted to a BP range of 130–139 mmHg.

I

A

2019 ESC/EAS Guidelines for the management of dyslipidaemias: *lipid modification to reduce cardiovascular risk*

In primary prevention, people ≤ 75 years old should be treated according to the level of risk whereas older subjects may be considered for initiation of statin treatment if at high or very high risk.

The recommendation is to start with lower doses due to comorbidities - in particular renal impairment - altering pharmacokinetics, with potential accumulation and drug-drug interaction, and then titrate to target with caution.

Favouring statin therapy	Not generally speaking against statin therapy	Discouraging from statin therapy	Evidence particularly unclear and urgently needed
Diabetes mellitus	Advanced age	Difficulty adhering to current therapies	Frailty
Expected drug adherence	Mild to moderate renal insufficiency	(Multiple) interacting co-medication	
Absence of end-of-life situation		Serious adverse statin events in the past	
Patient preference		Competing non-vascular conditions likely limiting life expectancy	

Aspirin, cardiovascular events, and major bleeding in older adults: extended follow-up of the ASPREE trial

Table 3 Effects of aspirin as randomized on first major haemorrhagic events in the ASPREE trial and during post-trial observational follow-up

Endpoint	In-trial ^f Hazard ratio (95% CI)	Post-trial effects ^g			In-trial v post-trial P ^h	In-trial and post-trial (long-term effects)		
		Aspirin	Placebo	Hazard Ratio (95% CI)		Aspirin	Placebo	Hazard ratio (95% CI)
		N (rate) ^e	N (rate) ^e			N (rate) ^e	N (rate) ^e	
Major haemorrhage ^a	1.38 (1.18, 1.62)	272 (8.6)	258 (8.0)	1.08 (.91, 1.29)	.06	650 (8.8)	537 (7.1)	1.24 (1.10, 1.39)
Intracranial bleeding ^b	1.50 (1.11, 2.02)	76 (2.3)	91 (2.7)	.85 (.63, 1.16)	.03	189 (2.5)	170 (2.2)	1.13 (.92, 1.39)
Upper gastrointestinal bleeding	1.87 (1.32, 2.66)	70 (2.2)	65 (2.0)	1.10 (.79, 1.54)	.03	163 (2.2)	116 (1.5)	1.43 (1.13, 1.81)
Lower gastrointestinal bleeding	1.36 (.96, 1.54)	52 (1.6)	45 (1.4)	1.18 (.79, 1.76)	.64	125 (1.7)	100 (1.3)	1.27 (.97, 1.65)
Bleeding at another site ^c	1.16 (.87, 1.54)	86 (2.7)	66 (2.0)	1.33 (.96, 1.83)	.70	192 (2.5)	156 (2.0)	1.25 (1.01, 1.54)
Fatal major haemorrhage ^d	1.18 (.68, 2.03)	32 (.9)	33 (.9)	.99 (.61, 1.61)	.76	67 (.8)	62 (.8)	1.10 (.78, 1.55)

- Low-dose aspirin does **not** provide a significant reduction in major adverse cardiovascular events nor improve disability-free survival.
- Aspirin use is associated with a **clinically meaningful increase in major bleeding events**.

2024 ESC Guidelines for the management of chronic coronary syndromes

Developed by the task force for the management of chronic coronary syndromes of the European Society of Cardiology (ESC)

5.3. Other specific patient groups

Recommendations	Class ^a	Level ^b
Older adults		
In older adults (≥75 years), particular attention to drug side effects, intolerance, drug–drug interactions, overdosing, and procedural complications is recommended.	I	C
In older, as in younger, individuals, diagnostic and revascularization decisions based on symptoms, extent of ischaemia, frailty, life expectancy, comorbidities, and patient preferences are recommended.	I	C

In the setting of secondary prevention, ***low-dose aspirin (75–100 mg) remains indicated***, provided that bleeding risk is carefully assessed and periodically reassessed.



- Cardiovascular disease in older adults occurs amidst multiple comorbid conditions and geriatric syndromes.
- To meet the needs of older adults, clinicians should consider multicomplexity, cognition, physical function, and social factors.
- Clinicians should formulate comprehensive geriatric cardiology care plans grounded in individualized health care goals and preferences