In the process of aligning treatment options to fit each individual patient, the clinician must carefully evaluate how each decision affects the overarching goals of care. In the management of coronary artery disease, however, these tradeoffs are often confounded by a bias toward less invasive strategies in the elderly. Given that women outnumber men by 54% beyond the age of 80 years, this predisposition can also contribute to an insidious form of gender discrimination. Older patients are often excluded from major clinical trials, contributing to a lack of awareness surrounding the efficacy of aggressive treatments in this demographic. In their tandem contributions to this month’s journal, the research teams of Maor and Khullar introduce new weapons in the battle against ageism.

In presenting their data on 2317 patients with non–ST-segment elevation myocardial infarction from the Sheba Medical Center, Fishman and colleagues convincingly demonstrate that an aggressive approach to coronary angiography in older (≥80 years) patients leads to improved survival. As the largest published cohort to date in this patient group, the study also highlights the fact that frailty status should not be considered a contraindication to invasive measures. Missing from this analysis is a robust assessment of the 35% of patients who did not undergo coronary intervention on the basis of the findings of the left-sided heart catheterization. Specifically, we do not know how many of the patients were found to have complex anatomy or what percentage of these were considered for coronary artery bypass grafting (CABG).

FIGURE. Summary of outcomes with various treatment modalities in the management of octogenarians with coronary artery disease. CABG, coronary artery bypass grafting; NSTEMI, non–ST-segment elevation myocardial infarction.
Whereas risk aversion can often obscure judgment in the invasive management of octogenarians, the Mayo Clinic team has provided compelling new evidence that this should not be the case. Choi and colleagues present data on 1283 consecutive CABG procedures in older (≥80 years) patients, describing an operative mortality rate of 4% with a median survival time of 7.6 years. These findings are as notable for the questions they raise as for the ones that they answer. For instance, in the Surgical Treatment for Ischemic Heart Failure (STICH) trial, a significant difference between medical therapy and surgical revascularization with respect to the primary end point of death from any cause was absent at 5 years but identifiable at 10 years. Although ejection fraction was correlated with mortality in the present study, as demonstrated in Supplemental Figure 2, the median ejection fraction in quartile 1 (43%) was still above the cutoff used in STICH (35%). If and when CABG should be offered in the setting of ischemic cardiomyopathy remains an area for further study in this age group. Hybrid procedures are not mentioned in these results, but the strategy (and necessity) for complete revascularization might be another opportunity for deploying alternative approaches to lowering the operative risk.

These 2 studies provide an important reminder that age is simply 1 risk factor in the assessment of procedural risk (Figure). Although it is obvious that the long-term benefits of invasive treatments are proportional to the expected survival independent of cardiovascular risk, this should not serve as a justification to deny evidence-based therapies because of age alone. Without question, these complex situations require skill and creativity to define the optimal and appropriate strategy for each individual patient. Like the pieces of a jigsaw puzzle, there may often be only 1 combination of treatments that can provide the desired result in each unique case.

POTENTIAL COMPETING INTERESTS
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