Evidence of ageism in the management of acute coronary syndromes

SIR—Elder rightly points out that older people with acute coronary syndrome (ACS) are treated differently to younger patients [1]. Several studies have shown that they are less likely to receive evidence-based treatments despite higher risk of major coronary events. Although I agree that evidence of ageism is mounting and it probably does exist, the case is not yet proven. Could the differences in management and outcome be explained by confounding factors? In particular, data about co-morbidity in older patients are lacking. Older patients presenting with ACS typically had three other morbid conditions in one study [2]. Another recent study found an invasive strategy could safely and successfully be implemented in 77% of unselected patients with ACS aged 70 or over [3]. All the increase in rate of adverse events observed in the older cohort in the study arose from the remaining 23% who had contraindications. Outcomes were similar to other published series despite intention to treat aggressively irrespective of age.

Elder identifies two big obstacles to ensure compliance with National Service Frameworks for Older People and Coronary Heart Disease. The first is the limited availability of invasive interventions. Wherever there are limited resources it is always likely that those perceived to have lower life expectancy, whether due to co-morbidity or advanced age only, will lose out. Unless it can be proven that many interventions are ‘wasted’ on younger patients, it would be harsh to claim this is ageism. It has been estimated that achieving equity for women and older people up to the age of 79 would necessitate over 27,000 extra coronary artery bypass grafts and over 23,000 extra percutaneous interventions in England alone [4].

The second relates to patient selection. The management of acute coronary syndrome relies on risk stratification to identify those most likely to benefit from aggressive intervention [5]. Where is the evidence that commonly used risk stratification tools (e.g. ECG, troponin levels) are useful for identifying older patients who would benefit from intervention? The limitations of such simple tools have led to the development of more robust instruments. The GRACE (Global Registry of Acute Coronary Events) model is possibly the best, as it was developed from a large number of relatively unselected patients [6]. It is interesting that even this model performs worse (lower area under receiver operating characteristic curves) in the elderly than in any other sub-group.

Unless these issues can be resolved it is unlikely that older patients with ACS will benefit from similar treatment or outcomes than younger patients, and it will be impossible to prove that such inequalities are due to ageism.

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Managing the challenge of atrial fibrillation and stroke prevention in older people: new drugs or new approaches to improve outcomes?

SIR—Morgan’s review of the complexities of balancing benefit and harm in the anticoagulation of elders with atrial fibrillation (AF) provides a welcome opportunity to review current practices [1]. However, we feel there are additional important points that are of value for clinicians dealing with decisions relating to anticoagulation. An estimated 2.5 million patients are affected by AF across the UK and USA, and the rising prevalence of AF-related strokes with age presents a significant health care challenge [2]. A recent economic analysis has suggested that almost 1% of NHS expenditure in 2000 was attributable to AF and its related outcomes [3]. With AF rates estimated to rise over the next 50 years, it is vital that methods of accurately stratifying risk–benefit outcomes are sought [2].

Performing a risk–benefit analysis for older people presents a major challenge to the individual clinician who has to wrestle with an ever expanding evidence base that contains a relative paucity of good data on which to make important decisions because of the under-representation of older people in most studies looking at AF and its treatment. The emerging impact of a further risk factor for bleeding, namely that of microhaemorrhages, further complicates stroke prevention decision making. Up to 6% of healthy elders exhibit microhaemorrhages on magnetic resonance imaging, which have clearly been identified as a marker of increased haemorrhagic risk in patients treated with thrombolysis [4, 5]. Many risk factors such as hypertension and diabetes that are used to stratify stroke risk and inform decisions about anticoagulation have also been closely linked to small-vessel disease, linked with higher rates of intracerebral bleeding in prevention.