

## Risk factors of cardiovascular disease in older people and immediate management.

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### Abstract

**Heart disease is caused by atherosclerosis. Atherosclerosis is the formation of fatty deposits or plaques over years on the walls of the coronary arteries. Coronary arteries surround the outside of the heart and carry blood nutrients and oxygen to the heart muscle. Plaque build-up in arteries leaves less room for normal blood flow and oxygen supply to the heart. When plaque build-up reduces or blocks blood flow to the heart, a sudden rupture of the plaque can cause angina pectoris (chest pain or discomfort) or a heart attack. When the heart muscle does not get enough oxygen and nutrients in the blood, the heart muscle cells die (heart attack), weakening the heart and reducing its ability to pump blood to the rest of the body.**

**Keywords:** Atherosclerosis, Coronary arteries, Blood nutrients, Oxygen, Cardiovascular disease.

### Introduction

Adults over the age of 65 are more likely than younger people to suffer from cardiovascular disease, problems with the heart, blood vessels, or both. Aging and geriatric populations are particularly vulnerable to cardiovascular disease. Age is an independent risk factor for cardiovascular disease (CVD) in adults, but these risks are exacerbated by additional factors such as frailty, obesity and diabetes. These factors are known to complicate and exacerbate cardiac risk factors associated with onset in old age. Gender is another potential risk factor in older adults, with older women reportedly having a higher risk of cardiovascular disease than age-matched men [1]. However, in both men and women, the risks associated with CVD increase with age and these correspond to an overall decline in sex hormones, primarily of oestrogen and testosterone. Despite this, hormone replacement therapies are largely shown to not improve outcomes in older patients and may also increase the risks of cardiac events in older adults. This review discusses current findings regarding the impacts of age and gender on heart disease.

### *Factors assessing risk of cardiovascular disease in older people*

- Hypertension
- Smoking
- Dyslipidaemia
- Diabetes mellitus
- Obesity
- Sedentary lifestyle whose harmful effects accumulate over a lifetime.

In older people, the lifetime benefit from CVD risk-factor treatment should consider absolute CV risk, life expectancy, competing (non-CV) risks and efficacy and safety data from Randomized Controlled Trials (RCTs). Moreover, management decisions should be patient-centric and consider patient preferences, frailty, comorbidities and polypharmacy [2].

Symptomless manifestation or disease with discreet symptoms is relatively common (60% in those 85 years or older), but the clinical consequences of a silent event are just the same as of a coronary heart event with alarming symptoms [3]. The pitfall of asymptomatic ischemia is failure to take precautionary measures in time. Prevention is paramount, as the prognosis of myocardial infarction in the elderly is associated with poor prognosis. Dyspnoea is a very common symptom in both acute coronary syndrome and chronic CAD.

### *Diagnostic test*

As in young adults, an ECG is essential. However, older patients are more likely to have previous myocardial infarction, left ventricular hypertrophy, conduction abnormalities (particularly left bundle branch block) and pacing rhythms, all of which contribute to the difficulty of electrocardiographic diagnosis of ACS or chronic CAD.

### **Treatment**

Guideline-based treatments for stroke prevention depend on the underlying ethology. In elderly patients with nonvalvular atrial fibrillation, chronic anticoagulation reduces the risk of embolic stroke by approximately two-thirds. Additionally, anticoagulation therapy is recommended if stroke evaluation

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reveals a thrombus source [4]. Patients with carotid artery stenosis or other atherosclerotic etiologist should receive antiplatelet therapy, blood pressure control, intensive statin therapy, glucose control, smoking cessation, lifestyle interventions and regular follow-up.

Interventional therapy for extra cranial carotid artery stenosis in the elderly is based on many factors that should be considered in the risk-benefit equation. These include patient age and expected life expectancy. Symptomatic status; validated lesion severity; potential compliance with pharmacotherapy; brain anatomy and function; and vascular anatomic risk factors for stenting or endarterectomy [5]. The interventionist's or surgeon's experience, skills and documented results.

## Conclusion

A key priority for older adults is the prompt assessment and initiation of treatment for ACS. As previously mentioned, atypical presentations often delay response and care and contribute to poor outcomes in her older ACS patients. Rapid access to medical care and rapid initiation of pharmacological and invasive management in appropriate patients would be of great benefit. Evaluation also requires additional vigilance, as ACS often occurs in the context of comorbid conditions that can obscure and delay CAD-oriented priorities. Non-

cardiac morbidity is often a factor in CAD instability and its management.

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