Dr. D. Fullerton (Denver, Colorado, USA): As you mentioned in your introduction, this is the first study that I believe will be in the literature which takes different age populations and breaks them out individually and looks at what the risk factors are within a given age group, which is a very important question to ask, and I believe you have effectively asked it and answered it.

I have a couple of questions, but first I would like to remark that, number one, among the elderly group of patients, I was particularly struck by the fact that as you mentioned, there were higher risk, more urgent and emergency operations, more left main, this sort of thing, and yet their observed-to-expected mortality rates were really not different from the much lower risk and younger group of people. One might interpret those data to suggest that the age itself was not an independent risk factor. My first question, therefore, is: Is that true? Is that your conclusion as well, Dr. Saito?

Dr. Saito: As I presented in the list of risk factors, I couldn’t find any tendency in the risk profile in each age group. It might have been easier if there had been any particularly strong risk factors in the elderly, for example, those related to lung disorder or that kind of thing. However, those who bore in the elderly age group are just susceptible to any type of risk factors. I know that my comment or my conclusion might really not be giving any particular clue, and might be pretty boring, but I really should say that the elderly people are just weak in nature. I still can’t find my answer that the age itself is the risk or not.

Dr. Fullerton: Well, I don’t think your conclusion is boring at all. I think it’s really very important.

I’d like you, if you could, to please speculate, and this would be my second question. You began your talk by introducing the concept that as the population across the world ages and more elderly people come to surgery, every country is asking the question—can it afford to offer everyone an operation? So I’m curious, do you think your data will be used to help answer that question, or how will your data be used to help answer that question? Do you believe that some patients who are, for instance, elderly, who have significant mitral regurgitation or need a reoperation or resternotomy and who have some degree of aortic stenosis may be felt unsuitable candidates for surgery and not offered surgery?

Dr. Saito: I think I might say that the surgical outcome was pretty regardless of age, and that we were doing pretty well with surgical treatment considering the preoperative situation of each patient, that is, even though the patients were rather old. I don’t think these data would imply that elderly patients have less chance of receiving surgery, but rather, I would say that I hope this paper will encourage cardiac surgeons to accept these elderly people as surgical candidates.

Dr. Fullerton: I think you’re right.

eComment: Impact of age on outcomes after coronary artery bypass grafting

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We read with great interest the article by Saito et al. [1] highlighting the impact of age on short-term surgical outcomes after coronary artery bypass grafting (CABG) in the Japanese population. This is a useful contribution to the existing literature on the subject of cardiac surgery in the elderly that will aid in the decision-making process.

The incidence of cardiovascular disease is as high as 40% and it is the leading cause of death among the elderly [2]. Furthermore, these patients often have concomitant diseases, such as renal insufficiency, chronic obstructive pulmonary disease, peripheral vascular disease, prostatic enlargement complicated by urinary retention, and degenerative cerebral disease [3]. Despite these comorbidities, the demand for cardiac operations in elderly patients has increased over the last 10 years. Ten years ago, cardiac operations in patients aged 80 years and older were relatively uncommon [4]. Since then, there has been a marked increase in the number of operations performed in this age group.

The decision for surgery is complex in this group of patients and one must take into account several elements, such as the lack of synchronization between physiological age and chronological age, the quality of life, and the risk–benefit ratio. Furthermore, the risk of death from a cardiac operation in elderly patients can be reduced to that of younger patients with consistent and careful application of modern techniques and clinical practices. Last but not least, one must ensure that in order to achieve satisfactory outcomes in elderly patients, particularly octogenarians, operations in elderly patients who are seen to have potentially catastrophic clinical situations or comorbidities are avoided.

References


eComment: Increase in elderly patients undergoing cardiac surgery.
A worldwide phenomenon

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We read with great interest the article by Saito et al. [1], and we absolutely agree with their findings; in particular, the importance of using a local risk stratification system for preoperative assessment of cardiac surgical patients.

In Argentina, as well as in other countries, the ageing population is indeed an issue for several reasons. For instance, as physicians we face an increasing number of elderly patients suffering from preoperative comorbidities, a situation especially common among those undergoing cardiac surgery [2]. In this regard, it is worth mentioning that our risk model initially had 2.69% of the study population 80 years old or more. However, 10 years later the same age group represented 5.24% of the whole sample size (P<0.001). As stated by Saito et al. [1], the number of comorbidities increased in our validating population [2].

We strongly agree with the development of epidemiological studies in different parts of the world, such as the one published by Saito et al., since they provide good insight into the local population characteristics and risks models, clearly different from those found in Latin America [2], Asia [1], Europe [3] or North America [4].

References


