

Chicago Spring and ACC.16

It was easy to see that it was spring while boarding the plane in Istanbul. The Judas trees and tulips were the evidence of spring. After landing in Chicago and dealing with the aggravation of immigration and customs procedures, we finally managed to get out of the terminal and saw that spring was coming to Chicago even more slowly than we were. During the three days we stayed there, the temperature hovered between zero and five degrees. We also saw snow in April. However, as the title of this editorial implies, we did not come to visit this city for its unique architecture. So our interest in the weather of Chicago—an ideal city for congresses thanks to its congress center and centrally located hotels—was limited to the time we spent getting off the shuttle and entering the congress building. But believe me, it was limited this way many times.

Of course, my talk is not just about Chicago's weather and the environment. I'd like to mention a subject that caught my attention during the 2016 meeting of the American College of Cardiology. It's spring now, but one of the subjects addressed in the congress was old age, which we can be considered as the autumn of life. An increase in the number of elderly people with heart and coronary diseases in the population, which parallels the aging populations of societies, revealed that not only experts in geriatrics, but also cardiologists must deal with the issue. The congress did not neglect this issue.

If I'm to speak for myself, I noticed that the term and index of frailty, which I almost never use to evaluate elderly patients, is used as a prognostic determinant for almost every disease you know. The need to consider frailty when treatment modality for elderly patients was emphasized. In addition, atypical syndromes were reported to occur very frequently in frail elderly people. It was also mentioned that accurate evaluation of these patients requires environment, diet, physical adequacy, accompanying diseases and the medications patient use to be evaluated together with the patients' complaints.

Another issue about the elderly was addressed, namely, the number of the medications they use. Polypharmacy, which was first described in 1762 and refers to the use of four to nine drugs, was reported to occur very often in elderly people. The use of more than 10 drugs, known as megapharmacy, was reported to be frequent, too. It was also noted that the percentage of patients negatively affected by drug interactions increases with increases in the number of drugs used. For example, harmful drug interactions can be seen in 60% of the patients who use 11 drugs.

Every speaker made the point that recommendations for elderly patients with heart and coronary diseases were not based on concrete evidence. The fact that patients in their 80s, which

can be considered the equivalent of the 60s in the past, are not adequately represented in randomized controlled studies was described as the reason for the lack of concrete evidence. For example, in the studies that tested potent antiplatelets in acute coronary syndromes, the percentage of patients over 75 years of age was less than 15%. A review paper that has just been published found that the percentage of patients over 75 was roughly 20% in the acute coronary syndrome studies conducted since 1994, and this percentage has not increased for years.

This point about evidence must be taken to heart by researchers. The relation between elderly people and heart diseases is an undiscovered field. To find out about the research in our country, I searched with the key word, "elderly," only to find nine papers. Clearly, this is very little research. One reason for this may be that the number of elderly people in our country is lower than it is in western nations. According to 2014 census data—the most recent census—the number of people over 75 was found to be 251,300 and constituted 3% of the total population. Even if this percentage is low, the absolute number is considerable. It is acceptable to think that it would be not possible to enroll adequate number of elderly patients in a study in a single center in our country. However the results of well designed and conducted multi-center studies with no doubt will have international impact.

I began this paper by describing our trip to ACC.16 in Chicago. We learned that there was a van Gogh exhibition at the Art Institute of Chicago which was located somewhere between our hotel and the congress center. We could not return without paying a visit. We got the chance to see three of his famous bedroom paintings, which depict the same bedroom, side by side. These paintings are exhibited permanently in three different cities, one of which is Chicago. We learned how the tiny differences between these paintings reflect the painter's moods. I must emphasize that this exhibition method impressed everybody who's interested in this field.

We came back from Chicago where we experienced winter in springtime with a new research area that will contribute to our journal, too. We saw the paintings of a painter who died before getting old, remembered that we must pay more attention to the heart and coronary diseases of elderly people whose numbers are increasing each day, and most importantly, we saw that the content of the ACC's annual meeting had again achieved the richness it had in the old days.

Zeki Öngen
Editor
Istanbul-Turkey

