ORIGINAL ARTICLE

Cardiovascular Evidence Gaps in Adults Over 80 Years of Age. Part 2. Roundtable Results: Atrial Fibrillation and Acute Coronary Syndromes*

Brechas en la evidencia cardiovascular en adultos mayores de 80 años. Parte 2. Resultados de la roundtable: fibrilación auricular y síndromes coronarios agudos

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ABSTRACT

Background: Clinical practice guidelines have limitations when applied to patients > 80 years with atrial fibrillation (AF) or acute coronary syndrome (ACS), due to their underrepresentation in clinical trials and the interplay between frailty, multimorbidity, polypharmacy, functional status, and cognitive decline—factors that influence the appropriateness of interventions.
Objectives: The aim of this paper is to discuss gaps in management and to describe consensus-based therapeutic strategies for patients > 80 years with AF or ACS using a structured consensus methodology.
Methods: An in-person roundtable was held with 34 cardiologists and 6 geriatricians. Clinical scenarios for AF and ACS were analyzed and stratified into three functional categories: robust, mild frailty, and moderate frailty, with structured discussion and anonymous voting.
Results: Therapeutic decisions varied consistently with frailty category. In AF, the acceptance rate of rhythm control in newly diagnosed cases decreased with frailty (66.5% in the robust group versus 15.4% in the moderate frail group), even in the presence of cognitive decline. Beta-blockers were the most widely accepted pharmacologic option, with low support for digoxin and chronic amiodarone. Confidence in the CHA_2DS_2-VASc and HAS-BLED scores was low and decreased with frailty. Direct oral anticoagulants were the preferred option, although they were less widely accepted in cases of moderate frailty; acetylsalicylic acid was not supported as an alternative. In non-ST-segment elevation acute coronary syndrome (NSTE-ACS), acceptance of an early invasive strategy and the use of ticagrelor decreased with frailty. In ST-segment elevation ACS (STE-ACS) without access to cardiac catheterization laboratory, fibrinolytic therapy was considered an alternative, with greater support for more extensive infarcts and lower acceptance in cases of moderate frailty.
Conclusions: Frailty consistently influenced the treatment decisions reached by consensus in patients > 80 years with AF or ACS, with less acceptance of intensive strategies with higher levels of frailty. These findings underscore the need to incorporate a comprehensive assessment into cardiovascular decision-making.

Key words: Frailty - Comprehensive assessment in cardiology - Evidence-based medicine - Atrial fibrillation - Acute coronary syndromes - Older adults

RESUMEN

Introducción: Las guías de práctica clínica muestran limitaciones cuando se aplican a pacientes mayores de 80 años con fibrilación auricular (FA) o síndrome coronario agudo (SCA), por su baja representación en ensayos clínicos y por la interacción entre fragilidad, multimorbilidad, polifarmacia, funcionalidad y deterioro cognitivo, factores que condicionan la proporcionalidad de las intervenciones.
Objetivos: Discutir brechas en el manejo y describir estrategias terapéuticas consensuadas para pacientes mayores de 80 años con FA o SCA mediante una metodología estructurada de consenso.
Material y métodos: Se realizó una roundtable presencial con 34 cardiólogos y 6 geriatras. Se analizaron escenarios clínicos de FA y SCA estratificados en tres categorías funcionales: robusto, fragilidad leve y fragilidad moderada, con discusión estructurada y votación anónima.

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Resultados: Las decisiones terapéuticas variaron de manera consistente según el grado de fragilidad. En FA, la aceptación del control del ritmo en escenarios de reciente diagnóstico disminuyó con la fragilidad (66,5 % en robustos frente a 15,4 % en fragilidad moderada), incluso en presencia de deterioro cognitivo. Los betabloqueantes fueron la opción farmacológica más respaldada, con bajo apoyo para digoxina y amiodarona crónica. La confianza en los scores CHA_2DS_2-VASc y HAS-BLED fue baja y decreciente con la fragilidad. Los anticoagulantes orales directos fueron la opción preferida, aunque con menor aceptación en fragilidad moderada; el ácido acetilsalicílico no fue respaldado como alternativa. En síndrome coronario agudo sin elevación del segmento ST (SCASEST), la aceptación de una estrategia invasiva precoz disminuyó con la fragilidad, al igual que el uso de ticagrelor. En síndrome coronario agudo con elevación del segmento ST (SCACEST) sin disponibilidad de hemodinamia, la fibrinólisis fue considerada una alternativa, con mayor respaldo en infartos más extensos, y menor aceptación en fragilidad moderada.
Conclusiones: La fragilidad condicionó de manera consistente las decisiones terapéuticas consensuadas en pacientes mayores de 80 años con FA o SCA, con menor aceptación de estrategias intensivas a medida que aumentó su grado. Estos hallazgos refuerzan la necesidad de incorporar la valoración integral en la toma de decisiones cardiovasculares.

Palabras clave: Fragilidad - Valoración integral en cardiología - Medicina basada en la evidencia - Fibrilación auricular - Síndromes coronarios agudos - Adultos mayores

INTRODUCTION

In people > 80 years, chronological age alone does not describe the biological reserve or predict tolerance to interventions. In practice, highly heterogeneous patient profiles coexist along a clinical-functional continuum ranging from robustness to frailty, disability, and advanced disease, which directly impacts prognosis and therapeutic appropriateness. (1-4)

In this context, atrial fibrillation (AF) and acute coronary syndromes (ACS) represent common and highly complex clinical scenarios. The extrapolation of guidelines to this age group is limited by the underrepresentation of frail patients in clinical trials and by the frequent coexistence of multimorbidity, polypharmacy, cognitive decline, falls, and dependency. These factors influence the balance between ischemic benefit, hemorrhagic safety, and functional preservation. (3-5)

Following the initial publication of this consensus method, the present study reports the results for the AF and ACS scenarios obtained through a structured roundtable methodology. (6)

OBJECTIVES

The aim of this study was to identify and reach consensus on therapeutic strategies for patients > 80 years with AF or ACS, stratified by robustness, mild frailty, and moderate frailty.

METHODS

The roundtable was held in person in June 2024 in Buenos Aires, Argentina, and was attended by 40 referring physicians, 34 cardiologists and 6 geriatricians, with recognized clinical and academic careers.

The methodological process was structured in three stages to address the knowledge gaps systematically (Figure 1).

-*Gap identification:* In this initial phase, the organizing team of the Board of Directors of the Council on Cardiogeriatrics conducted an exhaustive review of recent literature and clinical practice guidelines. This analysis identified areas with insufficient evidence in the management of cardiovascular diseases in older adults and drew a preliminary list of knowledge gaps.

-*Scenario design:* In this stage, the usefulness of various frailty tools and diagnostic and therapeutic strategies in patients > 80 years was discussed and analyzed. In scenarios with comorbidities, the condition was considered stable, without end-stage disease. This population was divided into robust, mild frailty, and moderate frailty categories, which differ in terms of prognosis and treatment. Based on the proposed clinical scenarios, the different rounds were designed. Selected literature was sent to the participating physicians and and voting forms were designed to record votes that would be used during the discussion.

-*Discussion and consensus session:* Finally, the meeting was conducted using a structured methodology that combined open discussion followed by anonymous voting.

Votes were recorded on an electronic form (Google Forms®) with three options (Yes / Uncertain / No) and analyzed with a spreadsheet, without using statistical software packages. All the results are presented in Appendix 1. In each case, the strength of recommendation was classified into five categories based on the resulting percentage distribution. (Table 1)

All these stages were designed to ensure a comprehensive and systematic approach for generating practical recommendations to optimize cardiovascular care in older adults.

In each case, the strength of the recommendation is presented on a scale ranging from recommended to not recommended (Figure 2).

RESULTS (Central illustration)

Discussion scenarios

Round 1: Atrial fibrillation

Atrial fibrillation (AF) is the most common sustained arrhythmia, and its prevalence increases markedly with age. In patients > 80 years, the decision between rate control, rhythm control, and anticoagulation strategy must take into account not only thromboembolic and bleeding risks but also functional status, cognition, comorbidities, therapeutic burden, and care goals. (5)

a. Rate control vs. rhythm control (Figure 3)

In patients without cardiovascular disease (CVD) with preserved ejection fraction and a normal or mildly dilated left atrium, rhythm control was accepted by 66.5% in robust patients, 33.3% in those with mild frailty (with 28.2% being uncertain), and 15.4% in those with moderate frailty (with 20.5% being uncertain).

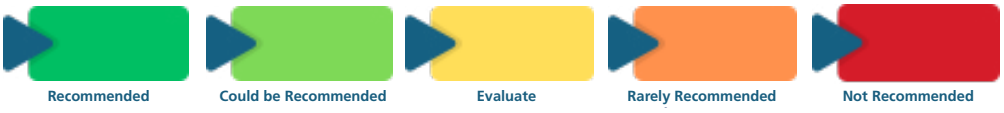
In the same scenario, but with cognitive decline, acceptance of rhythm control showed a stepwise pattern: 64% for robust patients (with 30.8% being un-

Table 2. Categories of strength of recommendation based on the distribution of the panel votes

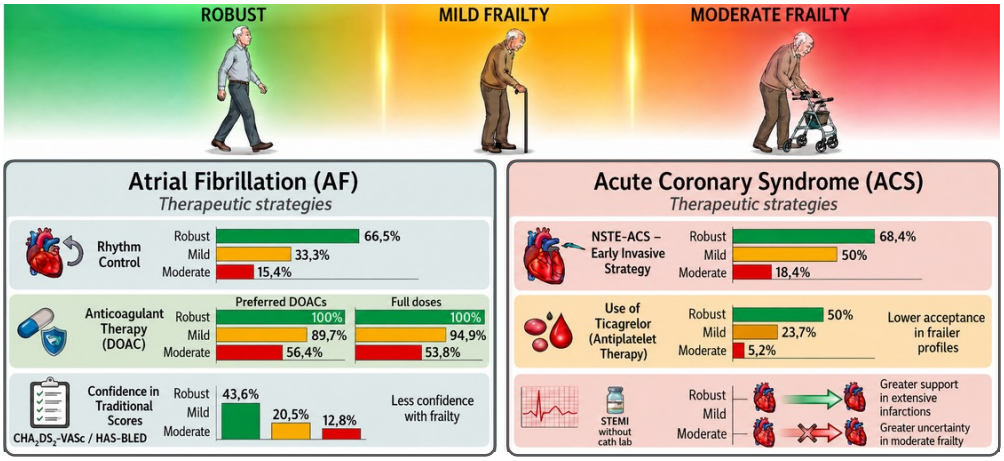
Category	Classification rule
Recommended	≥75% "Yes" votes
Could be recommended	50–74% "Yes" votes and <25% "No" votes
Evaluate	No option exceeds 50%, or "Uncertain" response predominates
Barely recommended	50–74% "No" votes and <25% "Yes" votes
Not recommended	≥75% "No" votes

Fig. 1. Roundtable methodology

Fig. 2. Level of recommendation



Central illustration. In subjects ≥ 80 years, frailty modulates the acceptance of therapeutic strategies for atrial fibrillation and acute coronary syndromes



DOACs: direct oral anticoagulants; F: frailty; NSTE-ACS: non-ST-segment elevation acute coronary syndrome; STE-ACS: ST-segment elevation acute coronary syndrome;

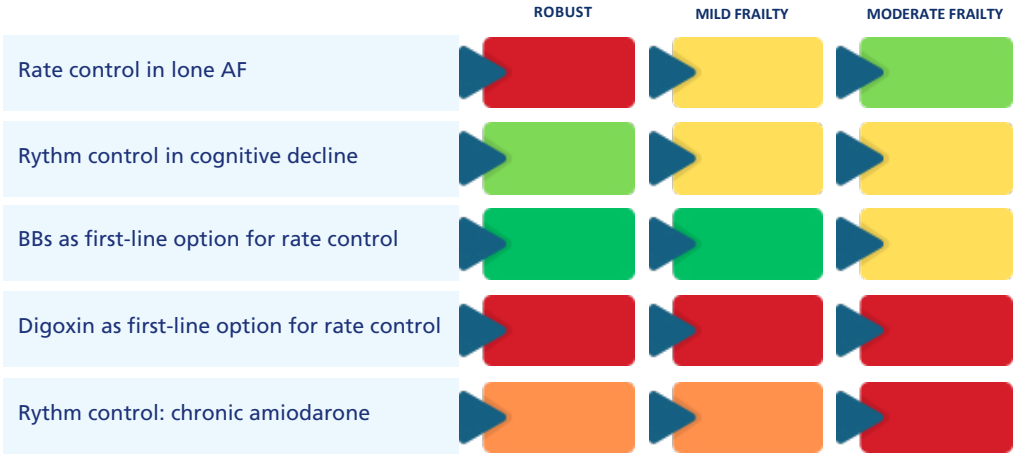
certain), 41% for mild frailty patients (with 36.9% being uncertain), and 30.8% for patients with moderate frailty (with 17.9% being uncertain).

For beta-blockers as first-line treatment, the acceptance rate was 94.9% for robust patients, 92.3% for patients with mild frailty, and 59% for patients with moderate frailty, (with 28.2% being uncertain).

Digoxin as first-line treatment had low acceptance across all profiles: 7.7% for robust patients, 2.5% for patients with mild frailty, and 5.1% for patients with moderate frailty.

The use of amiodarone for an indefinite period in a rhythm control strategy was accepted by 30.8% of participants for robust patients, 12.8% for mild frailty,

Fig. 3. AF: Rate control vs. rhythm control



AF: atrial fibrillation; BBs: beta blockers; HR: heart rate

and 7.7% for moderate frailty, with declining acceptance as frailty increased. (Appendix 1)

Opinion: The higher acceptance rate of rhythm control in robust patients and its marked decline in frail patients are consistent with the available evidence and its limitations on applicability. The EAST-AFNET 4 study demonstrated a clinical benefit of early rhythm control in patients with newly diagnosed AF; however, that study included a younger population with limited representation of frail patients; therefore, extrapolation to octogenarians should be done cautiously. (5,7,8) The lower acceptance in the presence of cognitive decline and the observed level of uncertainty suggest that participants considered broader objectives than mere symptom control, in a context where AF has been associated with an increased risk of cognitive decline and dementia even after adjusting for overt cerebrovascular events. (9) Regarding rate control, the high acceptance of beta-blockers among robust and mildly frail patients is consistent with guidelines. Conversely, the lower support among those with moderate frailty likely reflects concerns about hypotension, bradycardia, and falls. In this subgroup, a strategy of lenient heart rate control may be a particularly relevant option. (5,10) The limited support for digoxin and the growing reluctance toward chronic amiodarone can also be interpreted as a prudent stance, given their narrow therapeutic range, variability in renal function, and the risk of cumulative toxicity in very old adults. (5)

b. Anticoagulation (Figure 4)

Confidence in the CHA_2DS_2-VASc and HAS-BLED scores was 43.6% for robust patients, 20.5% for those with mild frailty, and 12.8% for those with moderate frailty, with a predominance of negative responses in all groups.

Regarding the choice of anticoagulants, direct oral anticoagulants (DOACs) had an acceptance rate of 100% for robust patients, 89.7% for those with mild frailty, and 56.4% for those with moderate frailty. Apixaban was the preferred option, followed by rivaroxaban.

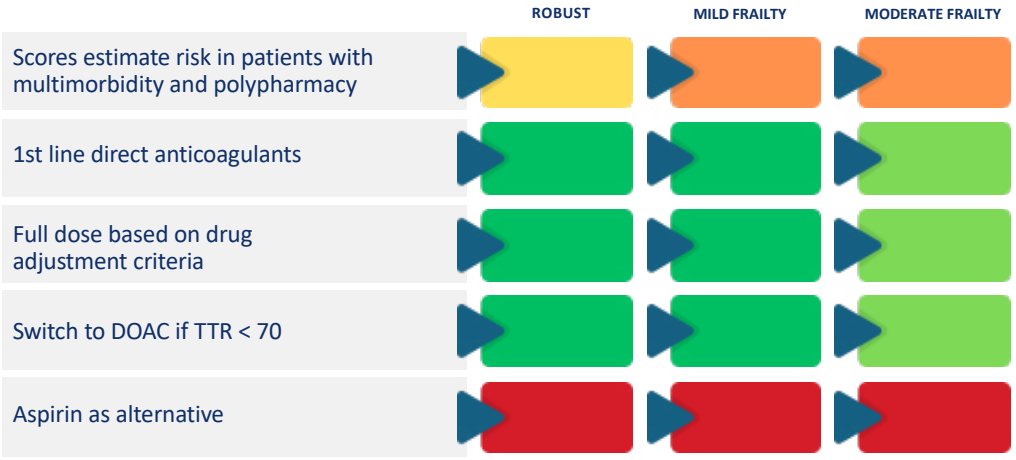
The use of full-dose therapy showed 100% acceptance for robust patients, 94.9% for those with mild frailty, and 53.8% for those with moderate frailty; in the latter group, 30.8% expressed uncertainty and 15.4% reported disapproval.

Regarding transition strategies, switching from vitamin K antagonists (VKAs) to DOACs in the event of suboptimal time in the therapeutic range (TTR) (<70%) showed an acceptance rate of 94.9% for robust patients, 79.5% for those with mild frailty, and 66.7% for those with moderate frailty.

The use of acetylsalicylic acid (ASA) as an alternative in patients at risk of falls or bleeding had very low acceptance rates across all groups: 15.4% for robust patients, 12.8% for mildly frail patients, and 12.8% for moderately frail patients.

Opinion: The decline in confidence in the CHA_2DS_2-VASc and HAS-BLED scores as frailty increases is to be expected in this context, since both tools estimate thromboembolic risk and bleeding risk but do not explicitly incorporate variables common in octogenarians, such as functional status, cognitive decline, medication burden, dependence, or social vulnerability. However, their usefulness does not disappear in this group: they remain a starting point for risk stratification and, in the case of the HAS-BLED score, for identifying modifiable factors rather than to contraindicate anticoagulation. (5,8) The preference for DOACs, with apixaban as the most commonly chosen option, is consistent with the available evidence and with the analyses of older patients from pivotal trials, which demonstrated at least comparable efficacy and a favorable safety profile compared with

Fig. 4. Anticoagulation



DOAC: direct oral anticoagulant; TTR: time in the therapeutic range

VKAs. (5,11) The lower acceptance rate for patients with moderate frailty may reflect reasonable caution rather than a disapproval of anticoagulation per se. In patients ≥80 years ineligible for standard anticoagulation, the ELDERCARE-AF study showed that edoxaban 15 mg reduced thromboembolic events compared with placebo. However, this was a highly selected population; therefore, these results should not be interpreted as supporting an empirical reduction in DOAC dosage outside the adjustment criteria established for each drug. Along these lines, the available evidence yields two practical messages: in non-anticoagulated patients or those initiating therapy, DOACs are generally the preferred strategy. Conversely, in frail patients who are stable on VKAs with good control, a routine switch to DOACs should not be assumed to be necessarily safer, as demonstrated by the FRAIL-AF trial. The limited support for ASA as an alternative was consistent with the available evidence: it is not an effective substitute for anticoagulation in preventing embolism in AF while increasing bleeding risk without a comparable benefit. (5,15)

Round 2: Acute coronary syndrome

Ischemic heart disease remains one of the leading causes of cardiovascular morbidity and mortality in older adults. In this group, ST-segment elevation ACS (STE-ACS) or non-ST-segment elevation ACS (NSTE-ACS), typically present with a higher burden of comorbidities, less typical symptoms, and frequent coexistence with frailty, cognitive decline, and polypharmacy—factors that complicate both prognostic stratification and the choice between invasive and conservative strategies. (16,17)

a. Management strategy for NSTE-ACS (Figure 5)

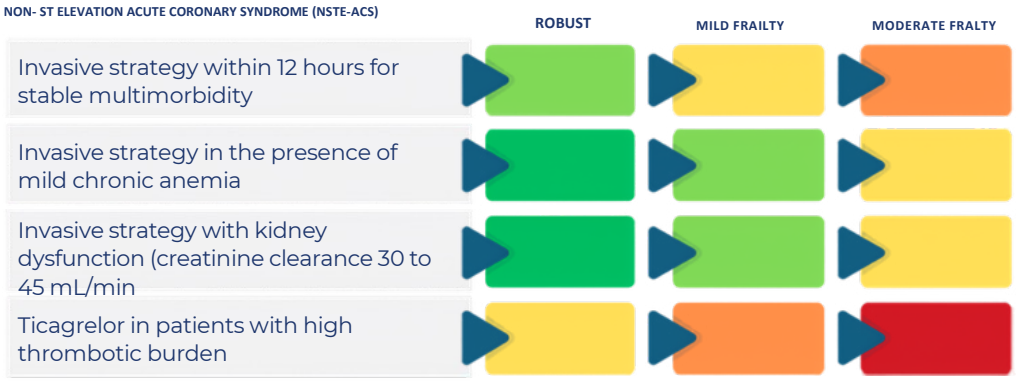
The acceptance of acceptance for an early invasive strategy was 68.4% for robust patients, 50% for those with mild frailty, and 18.4% for those with moderate frailty (with 39.5% being uncertain).

In the same scenario but with the presence of mild chronic anemia, 73.7% agreed with an early invasive strategy for robust patients, 57.9% for those with mild frailty, and 23.7% for those with moderate frailty, with 44.7% of uncertainty in the latter group. In the presence of chronic kidney disease (creatinine clearance of 30–45 mL/min), acceptance rates were 71.1%, 55.3%, and 21.1%, respectively.

Regarding the use of ticagrelor, the acceptance rate was 50% for robust patients, 23.7% for those with mild frailty, and 5.2% for those with moderate frailty.

Opinion: The decline in the acceptance rate for an early invasive strategy as frailty increases is consistent with current evidence and recommendations for individualized care. In the SENIOR-RITA trial, conducted in patients >75 years with NSTE-ACS, a routine invasive strategy did not reduce the composite primary outcome of cardiovascular death or nonfatal myocardial infarction at 4.1 years; yet the rate of nonfatal myocardial infarction was lower. Therefore, the overall benefit was inconclusive and must be weighed against comorbidities, functional prognosis, and care goals. The individual meta-analysis by Kotanidis et al. also showed no reduction in mortality with an invasive strategy in elderly patients, even though the reinfarction and urgent revascularization rates were lower. (19) In specifically frail patients, data from the MOSCA-FRAIL study and its subsequent analyses reinforce that the Clinical Frailty Scale can modify the risk-benefit balance and that the utility of an invasive strategy decreases as frailty increases. (20) Therefore, the lower acceptance rate in cases of moderate frailty could be interpreted not as an unjustified omission, but as a prudent assessment of a more uncertain benefit. The persistence of the same pattern in the presence of mild anemia or renal impairment suggests

Fig. 5. Strategy in NSTE-ACS



that, in the panel's decision-making process, frailty carried at least as much weight as these comorbidities. The low preference for ticagrelor in cases of mild and moderate frailty is consistent with the POPular AGE study, in which clopidogrel reduced bleeding and was non-inferior for the net clinical outcome in patients ≥ 70 years or older with NSTE-ACS. (21)

b. Management strategy for STE-ACS (Figures 6 and 7)

In the absence of catheterization laboratory capability, the use of fibrinolytic therapy for inferior myocardial infarction was supported by 81.6% for robust patients, 65.8% for those with mild frailty, and 23.7% for those with moderate frailty, with 39.5% of uncertainty for the latter group.

The acceptance rate of fibronolytic therapy for inferoposterolateral infarctions was 97.4% for robust patients, 84.2% for those with mild frailty, and 57.9% for those with moderate frailty. For anterior infarctions, 97.4% supported the use of fibrinolytic therapy for robust patients, 94.7% for those with mild frailty, and 65.8% for those with moderate frailty.

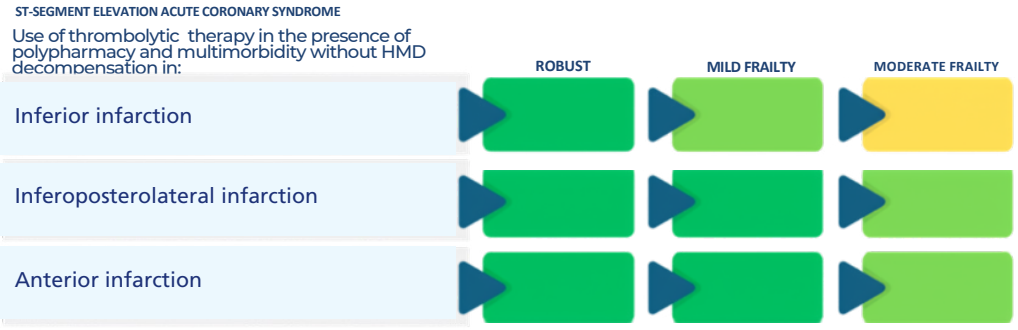
Opinion: The higher acceptance rate of fibrinolytic therapy in infarctions involving a larger area at risk is clinically consistent with a greater willingness to indicate a pharmaco-invasive strategy when timely primary percutaneous coronary intervention is not feasible. Nevertheless, primary percutaneous intervention remains the preferred strategy whenever it is feasible within the recommended time windows. (16) In older adults, fibrinolytic therapy requires rigorous screening for contraindications and a particularly careful assessment of the bleeding risk. The STREAM-2 study showed that a pharmaco-invasive strategy using half-dose tenecteplase in patients > 60 years or older without timely access to the catheterization laboratory achieved clinical efficacy comparable to that of primary percutaneous coronary intervention, but at the cost of a higher rate of intracranial hemorrhage. (22) Consequently, the support observed for robust patients and for those with mild frailty can be interpreted as reasonable in the absence of catheterization laboratory capability, while the higher uncertainty for patients with moderate frailty adequately reflects the potential hemorrhagic risk.

Regarding antithrombotic strategies and shortening the duration of dual antiplatelet therapy, the acceptance rate was 10.5% for the robust group, 18.4% for the mildly frail group, and 44.7% for the moderately frail group.

The use of a P2Y12 receptor inhibitor without ASA showed an acceptance rate of 26.3% for robust patients, 18.4% for mild frailty, and 23.7% for the moderate frailty. In the presence of AF in this scenario, the use of P2Y12 inhibitors in combination with anticoagulants and without ASA had an acceptance rate of 78.9% for the robust group, 65.8% for the mild frailty group, and 31.6% for the moderate frailty group, with 42.1% expressing uncertainty in the latter situation.

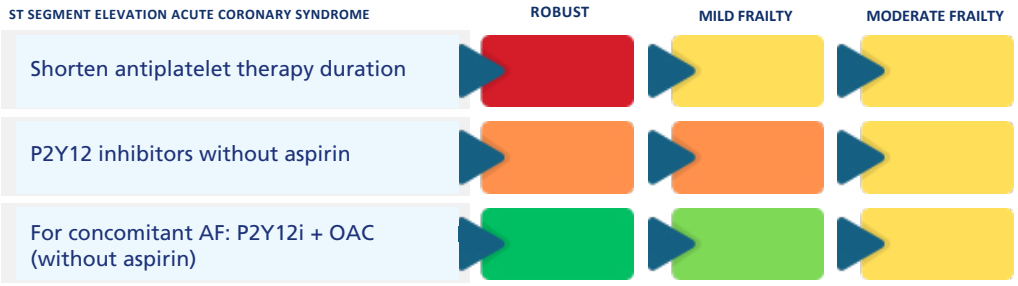
Opinion: The higher level of consensus on shortening dual antiplatelet therapy (DAPT) in moderate frailty is consistent with the increasing prominence of bleeding risk in this subgroup but requires prudent formulation. The MASTER DAPT trial demonstrated that, in patients at high risk of bleeding, an abbreviated therapy one month after a PCI was non-inferior in terms of net clinical events and reduced bleeding, supporting shorter strategies in selected patients. (23) However, this finding should not be automatically extrapolated to all frail octogenarians with ACS. in the STOPDAPT-2 ACS trial, clopidogrel monotherapy after 1 to 2 months of DAPT failed to attest noninferiority for the net clinical benefit with a numerical increase in cardiovascular events despite reduction in bleeding events. (24) Therefore, the results of the panel can be interpreted as consistent with a selective strategy in patients at high bleeding risk and not as a general rule. The low acceptance rate of a P2Y12 inhibitor monotherapy without ASA as a stand-alone strategy is also consistent with the fact that evidence on ACS in very old adults remains limited. In the presence of concomitant AF, the preference for oral anticoagulation combined with a single P2Y12 inhibitor

Fig. 6. Thrombolytic therapy in STE-ACS



HMD: hemodynamic

Fig. 7. Antithrombotic strategies in STE-ACS



AF: atrial fibrillation; OAC: oral anticoagulants; P2Y12i: P2Y12 inhibitor

and without ASA is consistent with the AUGUSTUS, ENTRUST-AF PCI, and PIONEER AF-PCI studies, which showed less bleeding rate with dual regimens than with triple therapy, without a consistent signal of reduction in ischemic efficacy. (25-27)

STUDY LIMITATIONS

The main limitations stem from the methodology used, which is based on expert consensus; this implies that the recommendations reflect the experience and clinical judgment of the participants. Although the group consisted of leading experts in cardiology and geriatrics, most are not exclusively dedicated to cardiogeriatrics. Therefore, these recommendations should be validated in future studies to confirm and refine these findings in clinical practice. Addressing multiple scenarios also limited the time available for discussion

CONCLUSION

In subjects > 80 years, AF and ACS present therapeutic decisions in which age alone is insufficient to guide management. Across the scenarios analyzed, frailty emerged as a consistent moderator of the acceptance of invasive strategies, the use of antiarrhythmic drugs, and the intensity of antithrombotic therapy.

In AF, the consensus consistently supported beta-blockers and DOACs, with less support for rhythm control and more intensive strategies when frailty or cognitive decline increased. In ACS, acceptance of early invasive strategies and more potent antiplatelet agents declined with frailty. Fibrinolysis was considered an alternative when timely access to a catheterization laboratory was not available, with greater support for larger infarcts.

These findings underscore the need to incorporate comprehensive assessment—along with ischemic and bleeding risk—into cardiovascular decision-making for the very elderly. Rather than replacing guidelines, this roundtable proposes a practical framework for tailoring approaches in common scenarios where evidence remains insufficient.

Conflicts of interest

None declared.

(See authors' conflict of interests forms on the web).

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REFERENCES

1. Lettino M, Mascherbauer J, Nordaby M, Ziegler A, Collet JP, Derumeaux G, et al. Cardiovascular disease in the elderly: proceedings of the European Society of Cardiology-Cardiovascular Round Table. Eur J Prev Cardiol. 2022;29:1412-1424. https://doi.org/10.1093/eurjpc/zwac033.

2. Goyal P, Kwak MJ, Al Malouf C, Kumar M, Rohant N, Damluji AA, et al. Geriatric Cardiology: Coming of Age. JACC Adv. 2022;1:100070. https://doi.org/10.1016/j.jacadv.2022.100070.

3. Rich MW, Chyun DA, Skolnick AH, Alexander KP, Forman DE, Kitzman DW, et al. Knowledge gaps in cardiovascular care of the older adult population: a scientific statement from the American Heart Association, American College of Cardiology, and American Geriatrics Society. Circulation. 2016;133:2103-2122. https://doi.org/10.1161/CIR.0000000000000380.

4. Palacio MS, Blanco P, Suárez G, Villalba Nuñez M, Schygiel P, Tavella MJ, et al. Documento de posición sobre fragilidad y valoración integral en Cardiología. Rev Argent Cardiol. 2025;93(Suplemento 2):1-87. https://doi.org/10.7775/rac.es.v93.s2

5. Van Gelder IC, Rienstra M, Bunting KV, Casado-Arroyo R, Caso V, Crijns HJGM, et al. 2024 ESC Guidelines for the management of atrial fibrillation developed in collaboration with EACTS. Eur Heart J. 2024;45:3314-3414. https://doi.org/10.1093/eurheartj/ehae176.

6. Suárez G, Blanco P, Palacio MS, Schygiel P, Villalba Núñez M, Flor ML, et al. Cardiovascular Evidence Gaps in Adults Over 80 Years of Age. Rev Argent Cardiol. 2025;93:192-201. https://doi.org/10.7775/rac.es.v93.i3.20897.

7. Willems S, Borof K, Brandes A, Breithardt G, Camm AJ, Crijns HJGM, et al. Systematic, early rhythm control strategy for atrial fibrillation in patients with or without symptoms: the EAST-AFNET 4 trial. Eur Heart J. 2022;43:1219-1230. https://doi.org/10.1093/eurheartj/ehab593.

8. Labadet C, Hadid C, Celano L, Militello C, Di Tommaso F, Perez Valega L y cols. Consensos de Fibrilación Auricular 2025. Rev Argent Cardiol 2026;94(Suplemento 3):1-128. https://doi.org/10.7775/rac.es.v94.s3

9. Saglietto A, Matta M, Gaita F, Jacobs V, Bunch TJ, Anselmino M. Stroke-independent contribution of atrial fibrillation to dementia: a meta-analysis. Open Heart. 2019;6:e000984. https://doi.org/10.1136/openhrt-2018-000984

10. Van Gelder IC, Groenveld HF, Crijns HJGM, Tuininga YS, Tijssen JGP, Alings AM, et al. Lenient versus strict rate control in patients with atrial fibrillation. N Engl J Med. 2010;362:1363-1373. https://doi.org/10.1056/NEJMoa1001337.

11. Halvorsen S, Atar D, Yang H, De Caterina R, Erol C, Garcia D, et al. Efficacy and safety of apixaban compared with warfarin according to age for stroke prevention in atrial fibrillation: observations from the ARISTOTLE trial. Eur Heart J. 2014;35:1864-1872. https://doi.org/10.1093/eurheartj/ehu046.

12. Okumura K, Akao M, Yoshida T, Kawata M, Okazaki O, Akashi S, et al. Low-dose edoxaban in very elderly patients with atrial fibrillation. N Engl J Med. 2020;383:1735-1745. https://doi.org/10.1056/NEJMoa2012973

13. Nicolau AM, Giugliano RP, Zimerman A, Afilalo J, Gencer B, Steffel J, et al. Outcomes in Older Patients After Switching to a Newer Anticoagulant or Remaining on Warfarin: The COMBINE-AF Substudy. J Am Coll Cardiol. 2025;86:426-439. doi: 10.1016/j.jacc.2025.05.060.

14. Joosten LPT, van Doorn S, van de Ven PM, Köhlen BTG, Nierman MCN, Koek HL, et al. Safety of switching from a vitamin K antagonist to a non-vitamin K antagonist oral anticoagulant in frail older patients with atrial fibrillation: results of the FRAIL-AF randomized controlled trial. Circulation. 2024;149:279-289. https://doi.org/10.1161/CIRCULATIONAHA.123.066485.

15. Mitchell A, Elmasry Y, van Poelgeest E, Welsh TJ. Anticoagulant use in older persons at risk for falls: therapeutic dilemmas-a clinical review. Eur Geriatr Med. 2023;14:683-696. https://doi.org/10.1007/s41999-023-00811-z.

16. Byrne RA, Rossello X, Coughlan JJ, Barbato E, Berry C, Chieffo A, et al. 2023 ESC Guidelines for the management of acute coronary syndromes. Eur Heart J. 2023;44:3720-3826. https://doi.org/10.1093/eurheartj/ehad191.

17. Abdulla AD, Forman DE, Wang TY, Chikwe J, Kunadian V, Rich MW, et al. Management of acute coronary syndrome in the older adult population: a scientific statement from the American Heart Association. Circulation. 2023;147:e32-e62. https://doi.org/10.1161/CIR.0000000000001112.

18. Kunadian V, Mossop H, Shields C, Bardgett M, Watts P, Teare MD, et al. Invasive treatment strategy for older patients with myocardial infarction. N Engl J Med. 2024;391:1673-1684. https://doi.org/10.1056/NEJMoa2407791.

19. Kotanidis CP, Mills G, Bebb O, Hildick-Smith D, Hirlekar G, Milasinovic D, et al. Invasive vs conservative management of older patients with non-ST-elevation acute coronary syndrome: individual patient data meta-analysis. Eur Heart J. 2024;45:2052-2062. https://doi.org/10.1093/eurheartj/ehae151.

20. Sanchis J, Ariza-Solé A, Abu-Assi E, Alegre O, Alfonso F, Barrabés JA, et al. Geriatric conditions and invasive management in frail patients with NSTEMI. A subgroup analysis of a randomized clinical trial. Rev Esp Cardiol (Engl Ed). 2025;78:319-326. https://doi.org/10.1016/j.rec.2024.08.006.

21. Gimbel M, Qaderdan K, Willemsen L, Hermanides R, Bergmeijer T, de Vrey E, et al. Clopidogrel versus ticagrelor or prasugrel in patients aged 70 years or older with non-ST-elevation acute coronary syndrome (POPular AGE): the randomised, open-label, non-inferiority trial. Lancet. 2020;395:1374-1381. https://doi.org/10.1016/S0140-6736(20)30325-1.

22. Van de Werf F, Ristić AD, Averkov OV, Arias-Mendoza A, Lambert Y, Kerr Saraiva JF, et al. STREAM-2: half-dose tenecteplase or primary percutaneous coronary intervention in older patients with ST-segment-elevation myocardial infarction: a randomized, open-label trial. Circulation. 2023;148:753-764. https://doi.org/10.1161/CIRCULATIONAHA.123.064521.
23. Valgimigli M, Frigoli E, Heg D, Tijssen J, Jüni P, Vranckx P, et al. Dual antiplatelet therapy after PCI in patients at high bleeding risk. N Engl J Med. 2021;385:1643-1655. https://doi.org/10.1056/NEJMoa2108749.
24. Watanabe H, Morimoto T, Natsuaki M, Yamamoto K, Obayashi Y, Ogita M, et al. Comparison of clopidogrel monotherapy after 1 to 2 months of dual antiplatelet therapy with 12 months of dual antiplatelet therapy in patients with acute coronary syndrome: the STOPDAPT-2 ACS randomized clinical trial. JAMA Cardiol. 2022;7:407-417. https://doi.org/10.1001/jamacardio.2021.5244.
25. Lopes RD, Heizer G, Aronson R, Vora AN, Massaro T, Mehran R, et al. Antithrombotic therapy after acute coronary syndrome or PCI in atrial fibrillation. N Engl J Med. 2019;380:1509-1524. https://doi.org/10.1056/NEJMoa1817083.
26. Vranckx P, Valgimigli M, Eckardt L, Tijssen J, Lewalter T, Gargiulo G, et al. Edoxaban-based versus vitamin K antagonist-based antithrombotic regimen after successful coronary stenting in patients with atrial fibrillation (ENTRUST-AF PCI): a randomised, open-label, phase 3b trial. Lancet. 2019;394:1335-1343. https://doi.org/10.1016/S0140-6736(19)31872-0.
27. Gibson CM, Mehran R, Bode C, Halperin J, Verheugt FWA, Wildgoose P, et al. Prevention of bleeding in patients with atrial fibrillation undergoing PCI (PIONEER AF-PCI). N Engl J Med. 2016;375:2423-2434.https://doi.org/10.1056/NEJMoa1611594.

APPENDIX 1.

The results are expressed as percentages (%)

ATRIAL FIBRILLATION	Robust			Mild frail			Moderate frail		
	YES	UNCERTAIN	NO	YES	UNCERTAIN	NO	YES	UNCERTAIN	NO
Controlled multimorbidity, no CVD, PEF with normal or mild dilated LA. New onset AF. Do you use a rate-control strategy?	25.6	7.7	66.7	38.5	28.2	33.3	64.1	20.5	15.4
In the event of cognitive decline, do you use a rhythm-control strategy?	61.5	30.8	7.7	41	35.9	23.1	30.8	17.9	51.3
Rate control: BB as first-line treatment	94.9	0	5.1	92.3	5.1	2.6	59	28.2	12.8
Rate control: Digoxin as first-line treatment	7.7	25.6	66.7	2.6	15.4	82.1	5.1	20.5	74.4
If we choose for RHYTHM control: do you use chronic amiodarone?	30.8	25.6	43.6	12.8	41	46.2	7.7	28.2	64.1
Multimorbidity and polypharmacy: Do the scores estimate the risk for these groups?	43.6	20.5	35.9	20.5	28.2	51.3	12.8	30.8	56.4
Do you indicate direct anticoagulants as first-line treatment?	100	0	0	89.7	10.3	0	56.4	30.8	12.8
Do you indicate full dose according to dosage adjustment criteria for each drug?	100	0	0	94.9	5.1	0	53.8	30.8	15.4
Do you switch VKAs to DOACs with a TTR < 70?	94.9	0	5.1	79.5	12.8	7.7	66.7	12.8	20.5
In cases of multiple falls, do you consider ASA 100 mg as an alternative?	12.8	5.1	82.1	12.8	7.7	79.5	15.4	2.6	82.1
ACUTE CORONARY SYNDROME WITHOUT ST-SEGMENT ELEVATION	**Robust**			**Mild frail**			**Moderate frail**		
	YES	UNCERTAIN	NO	YES	UNCERTAIN	NO	YES	UNCERTAIN	NO
Multimorbidity presenting to the emergency department with a diagnosis of NSTE-ACS, clinically stable. Do you indicate an invasive procedure within 12 hours of admission?	68.4	15.8	15.8	50	28.9	21.1	18.4	39.5	42.1
In cases of mild chronic anemia, do you indicate an invasive strategy?	73	13.2	13.2	57.9	23.7	18.4	23.7	44.7	31.6
With a creatinine clearance of 30 to 45, would you indicate an invasive strategy?	71.1	23.7	5.3	55.3	31.6	13.2	21.1	36.8	42.1
For a patient with high thrombotic burden, would you prescribe ticagrelor?	50	15.8	3.2	23.7	28.9	47.4	5.3	23.7	71.1
ACUTE CORONARY SYNDROME WITH ST-SEGMENT ELEVATION	**Robust**			**Mild frail**			**Moderate frail**		
	YES	UNCERTAIN	NO	YES	UNCERTAIN	NO	YES	UNCERTAIN	NO
Multimorbidity and polypharmacy, without hemodynamic impairment—does this indicate thrombolytic therapy for an inferior myocardial infarction?	81.6	13.2	5.3	65.8	23.7	10.5	23.7	39.5	36.8
And for an IPL infarction?	97.4	2.6	0	84.2	15.8	0	57.9	28.9	13.2
In cases of anterior infarction?	97.4	0	2.6	94.7	5.3	0	65.8	28.9	5.3
Do you shorten the antiplatelet therapy time?	10.5	10.5	78.9	18.4	36.8	44.7	44.7	47.4	7.9
Would you use P2Y12 inhibitors without ASA in either case?	26.3	7.9	65.8	18.4	26.3	55.3	23.7	36.8	39.5
And in the presence of AF: P2Y12 inhibitors alone + AC?	78.9	2.6	18.4	65.8	21.1	13.2	31.6	42.1	26. 3

AC: anticoagulation; AF: atrial fibrillation; ASA: acetylsalicylic acid; BB: beta-blockers; CVD: cardiovascular disease; DOAC: direct oral anticoagulants; HR: heart rate; IPL: inferoposterolateral; LA: left atrium; NSTE-ACS: Non-ST-segment elevation acute coronary syndrome; PEF: preserved left ventricular ejection fraction; TTR: therapeutic range time; VKAs: vitamin K antagonists.