Georgian Scientists
ქართველი მეცნიერები
Vol. 8 Issue 4(1), 2026
https://doi.org/10.52340/gs.2026.08.04(1).58



FEATURES OF MYOCARDIAL INFARCTION MANAGEMENT IN OLDER ADULTS

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Managing myocardial infarction in older adults (≥75–80 years) presents a complex clinical challenge due to age-related physiological changes, multimorbidity, renal impairment, and biological frailty. Older patients frequently present with atypical clinical features without classic chest pain, displaying instead shortness of breath, sudden weakness, syncope, or delirium, which delays prompt diagnosis and risk stratification.

Regarding revascularization strategies, primary percutaneous coronary intervention (PCI) remains the standard of care for ST-elevation myocardial infarction (STEMI). In non-ST-elevation myocardial infarction (NSTEMI), evidence from trials such as SENIOR-RITA, FIRE, and After Eighty indicates that an early invasive approach and complete physiology-guided revascularization significantly reduce recurrent ischemic events and urgent revascularizations in functionally active seniors. Conversely, in severely frail individuals with excessive comorbidities, conservative optimal medical therapy is preferred.

Pharmacotherapy requires balancing heightened ischemic and bleeding risks. Due to high bleeding risk (HBR), shortening dual antiplatelet therapy (DAPT) duration (1–3 or ≤6 months) or adopting a uniform de-escalation strategy (e.g., transitioning to clopidogrel) significantly decreases major bleeding complications. For patients requiring oral anticoagulation, registry and clinical trial data (PERSEO, AUGUSTUS, RE-DUAL PCI) demonstrate that dual antithrombotic therapy combining a direct oral anticoagulant (DOAC) with a P2Y12 inhibitor is substantially safer than prolonged triple antithrombotic therapy (TAT). Concomitant gastroprotection with proton pump inhibitors (PPIs) and dosage adjustment of secondary prevention drugs according to renal function (eGFR) are essential.

Ultimately, management must integrate comprehensive geriatric assessments and a multidisciplinary team approach to transition from a disease-centered model to a person-centered care pathway prioritized around quality of life.

Keywords: Myocardial infarction, Elderly population, Geriatric cardiology, Percutaneous coronary intervention (PCI), STEMI, NSTEMI, Dual antiplatelet therapy (DAPT), High bleeding risk (HBR), Frailty, Person-centered care