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Pharmacotherapeutic Features of the Treatment of Ischemic Heart Disease in 60-Year-Old Patients

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Abstract

This article examines the specific pharmacotherapeutic aspects of managing ischemic heart disease in patients aged 60 years and older. In this age group, the selection of pharmacological treatment should take into account not only the clinical form and severity of the disease but also such factors as blood pressure, heart rate, renal and hepatic function, comorbidities, polypharmacy, and potential drug–drug interactions. The principal approaches to pharmacotherapy include the rational use of antianginal, antithrombotic, and lipid-lowering agents, as well as the effective management of cardiovascular risk factors. Individualized selection of drug dosage and therapeutic combinations according to the patient's clinical condition may help reduce the risk of adverse drug reactions and medication-related complications. Regular monitoring of treatment effectiveness, assessment of medication adherence, and timely adjustment of pharmacotherapy when necessary are also of particular importance. This approach facilitates the development of individualized pharmacotherapy aimed at controlling symptoms, reducing the risk of cardiovascular complications, and improving the safety of treatment in patients with ischemic heart disease.

Keywords

ischemic heart disease, patients aged 60 years and older, pharmacotherapy, antianginal agents, antithrombotic therapy, lipid-lowering therapy, polypharmacy, medication safety, individualized treatment, clinical pharmacology, pharmacotherapeutic monitoring.

60 yoshli bemorlarda yurak ishemik kasalliklarini davolashdagi farmakoterapevtik xususiyatlar.

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Annotatsiya. Ushbu maqolada 60 yosh va undan katta bemorlarda yurak ishemik kasalliklarini farmakoterapevtik davolashning o‘ziga xos jihatlari yoritilgan. Ushbu yosh guruhida dori vositalarini tanlashda kasallikning klinik shakli va og‘irligi bilan bir qatorda arterial bosim, yurak urish tezligi, buyrak va jigar faoliyati, hamroh kasalliklar, polifarmatsiya hamda dori vositalarining o‘zaro ta’siri kabi omillarni hisobga olish muhimdir. Farmakoterapiyaning asosiy yo‘nalishlari antianginal, antitrombotik va lipidni pasaytiruvchi preparatlardan oqilona foydalanishni, shuningdek, yurak-qon tomir xavf omillarini nazorat qilishni o‘z ichiga oladi. Bemorning individual klinik holatiga mos ravishda dori vositasining dozasi va kombinatsiyasini tanlash nojo‘ya reaksiyalar hamda dori bilan bog‘liq asoratlar xavfini kamaytirishga yordam beradi. Shuningdek, davolash samaradorligini muntazam monitoring qilish, bemorning davolanishga rioya etishini baholash va farmakoterapiyani zaruratga ko‘ra korreksiya qilish muhim ahamiyatga ega. Mazkur yondashuv yurak ishemik kasalligi bo‘lgan bemorlarda simptomlarni nazorat qilish, yurak-qon tomir asoratlari xavfini kamaytirish va davolash xavfsizligini oshirishga qaratilgan individual farmakoterapiyani shakllantirish imkonini beradi.

Kalit so‘zlar: yurak ishemik kasalligi, 60 yosh va undan katta bemorlar, farmakoterapiya, antianginal preparatlar, antitrombotik terapiya, lipidni pasaytiruvchi terapiya, polifarmatsiya, dori vositalari xavfsizligi, individual davolash, klinik farmakologiya, farmakoterapevtik monitoring.

Фармакотерапевтические особенности лечения ишемической болезни сердца у пациентов 60-летнего возраста

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Аннотация. В статье рассматриваются особенности фармакотерапии ишемической болезни сердца у пациентов в возрасте 60 лет и старше. В данной возрастной группе при выборе лекарственной терапии важно учитывать не только клиническую форму и степень тяжести заболевания, но и такие факторы, как уровень артериального давления, частота сердечных сокращений, функциональное состояние почек и печени, сопутствующие заболевания,

полипрагмазия и возможные лекарственные взаимодействия. Основными направлениями фармакотерапии являются рациональное применение антиангинальных, антитромботических и гиполипидемических препаратов, а также контроль факторов сердечно-сосудистого риска. Индивидуальный подбор дозировок и комбинаций лекарственных средств с учетом клинического состояния пациента позволяет снизить вероятность развития нежелательных лекарственных реакций и осложнений, связанных с фармакотерапией. Существенное значение имеют регулярный мониторинг эффективности лечения, оценка приверженности пациента терапии и своевременная коррекция фармакотерапии при необходимости. Такой подход способствует формированию индивидуализированной фармакотерапии, направленной на контроль симптомов, снижение риска сердечно-сосудистых осложнений и повышение безопасности лечения пациентов с ишемической болезньюсердца.

Ключевые слова: ишемическая болезнь сердца, пациенты в возрасте 60 лет и старше, фармакотерапия, антиангинальные препараты, антитромботическая терапия, гиполипидемическая терапия, полипрагмазия, безопасность лекарственной терапии, индивидуализированное лечение, клиническая фармакология, фармакотерапевтический мониторинг.

Introduction. Ischemic heart disease (IHD) is a chronic cardiovascular condition associated with impaired coronary blood flow and an imbalance between myocardial oxygen supply and demand. Its clinical manifestations range from stable anginal symptoms to acute coronary events. Pharmacotherapy plays a central role in symptom control, prevention of cardiovascular events, and improvement of long-term clinical outcomes.The pharmacological management of patients with IHD has become increasingly individualized. Contemporary guidelines emphasize that treatment decisions should be based not only on the presence of coronary artery disease but also on the patient's symptoms, cardiovascular risk, ventricular function, previous myocardial infarction or revascularization, concomitant diseases, and individual treatment goals. The 2024 European Society of Cardiology guidelines specifically address antianginal therapy, antithrombotic treatment, lipid lowering, prevention of cardiovascular events,

adherence, and long-term follow-up in chronic coronary syndromes. Patients aged 60 years require particular attention because age-related physiological changes may influence pharmacokinetics and pharmacodynamics even before advanced old age is reached. The presence of hypertension, diabetes mellitus, chronic kidney disease, dyslipidemia, arrhythmias, heart failure, or other comorbidities may further complicate pharmacotherapeutic decision-making. Consequently, the treatment strategy should be individualized rather than based solely on chronological age. Antianginal Pharmacotherapy.The principal objective of antianginal treatment is to reduce myocardial ischemia and improve the patient's functional capacity and quality of life. According to contemporary recommendations, a beta-blocker or calcium-channel blocker can be selected as first-line antianginal therapy, with the choice determined by the patient's clinical characteristics and contraindications. [1,2]. Long-acting nitrates and other antianginal agents can be incorporated when symptoms remain inadequately controlled. Importantly, the purpose of antianginal therapy should not be limited to reducing the frequency of chest pain; the underlying cardiovascular risk profile must also be addressed. Beta-blockers reduce myocardial oxygen demand primarily through reduction of heart rate and myocardial contractility. They may be particularly appropriate when IHD is accompanied by tachycardia, hypertension, certain arrhythmias, or left ventricular systolic dysfunction. However, their prolonged use should have a clearly defined clinical indication. The 2023 AHA/ACC guideline notes that long-term beta-blocker therapy is not recommended solely for outcome improvement in patients with chronic coronary disease who do not have a recent myocardial infarction, reduced left ventricular ejection fraction, or another primary indication. Calcium-channel blockers provide another important therapeutic option. Their selection may be useful when beta-blockers are contraindicated, poorly tolerated, or insufficient for symptom control. The choice between dihydropyridine and non-dihydropyridine calcium-channel blockers should take into account heart rate, ventricular function, conduction abnormalities, and concomitant medications. Antiplatelet and Antithrombotic Therapy. Antithrombotic treatment is an important component of secondary prevention in patients with established coronary artery disease.

Aspirin and, in appropriate clinical circumstances, other antiplatelet agents may be used according to the patient's history and treatment strategy. In patients undergoing percutaneous coronary intervention, the duration and combination of antiplatelet therapy require individualized assessment. A particularly important consideration is the balance between thrombotic and bleeding risks. The 2023 AHA/ACC guideline indicates that shorter durations of dual antiplatelet therapy can be appropriate in many situations, particularly when bleeding risk is high and ischemic risk is low to moderate. Therefore, antiplatelet treatment should not be prescribed according to a fixed age-based formula. Previous myocardial infarction, coronary intervention, concomitant anticoagulant therapy, history of bleeding, renal function, and other clinical factors should be evaluated before selecting the regimen and its duration. Lipid-Lowering Therapy Lipid management represents one of the fundamental components of secondary prevention in IHD. Statins remain the principal pharmacological option for reducing low-density lipoprotein cholesterol and cardiovascular risk in patients with chronic coronary disease. If the desired lipid-lowering response is not achieved with maximally tolerated statin therapy, additional agents may be considered for selected patients. The 2023 AHA/ACC guideline identifies ezetimibe and PCSK9-targeting therapies among options that may be used in appropriate clinical situations. [5,6,7].

Results. For a 60-year-old patient, lipid-lowering treatment should therefore be considered as a long-term preventive strategy rather than merely a method of correcting a laboratory abnormality. Treatment effectiveness should be assessed through appropriate lipid monitoring and clinical follow-up.

Individualization of Pharmacotherapy. One of the major pharmacotherapeutic challenges in patients with IHD is the coexistence of several chronic conditions requiring multiple medications. Polypharmacy can increase the probability of drug–drug interactions, dosing errors, reduced adherence, and adverse drug reactions. Although the 2023 AGS Beers Criteria are specifically intended for adults aged 65 years and older and therefore do not directly classify a 60-year-old patient as an older adult under those criteria, their broader principles concerning medication review, drug interactions, renal-dose adjustment, and individualized prescribing are relevant concepts when considering

medication safety. Renal and hepatic function should be considered when medications depend substantially on these organs for elimination or metabolism. Blood pressure, heart rate, electrolyte status, renal function, lipid profile, and clinical symptoms may need periodic assessment depending on the treatment regimen. A rational pharmacotherapeutic strategy can therefore be represented as a continuous clinical sequence*: clinical assessment → identification of therapeutic goals → selection of pharmacological strategy → individual drug selection → dose adjustment → evaluation of contraindications and interactions → monitoring → assessment of therapeutic response → modification of treatment when necessary.*[9,10,11].This approach transforms pharmacotherapy from a static prescription into an ongoing process of clinical decision-making.

Medication safety and adherence.

Discussion. The pharmacotherapy of IHD in 60-year-old patients should be based on the interaction between disease characteristics and individual patient factors. The therapeutic objective is not simply to prescribe the largest possible number of cardiovascular drugs, but to construct a rational regimen in which every medication has a defined clinical purpose. Current recommendations support a combination of symptomatic treatment and strategies aimed at reducing cardiovascular risk. Antianginal agents address ischemic symptoms, whereas antiplatelet and lipid-lowering therapies contribute to prevention of cardiovascular events. Beta-blockers have an important role in selected patients, but their long-term use should be linked to an appropriate indication rather than chronological age alone. The patient's response to treatment should be assessed dynamically. Persistence or worsening of angina, excessive reduction in blood pressure or heart rate, development of adverse drug reactions, deterioration of renal function, or changes in comorbid conditions may require modification of the pharmacotherapeutic regimen. [15,16]. Thus, clinical pharmacology has an important role in optimizing treatment by integrating pharmacodynamic effects, pharmacokinetic characteristics, patient-specific risk factors, drug interactions, and therapeutic monitoring.

Conclusion. Pharmacotherapy of ischemic heart disease in 60-year-old patients requires an individualized and clinically reasoned approach. The principal therapeutic

components include appropriate antianginal treatment, evidence-based antiplatelet therapy, intensive lipid management, and control of associated cardiovascular risk factors. He selection and duration of therapy should be determined by the patient's clinical condition rather than age alone. Particular attention should be given to comorbidities, renal and hepatic function, potential drug interactions, adverse reactions, and medication adherence. Regular monitoring allows clinicians to identify changes in therapeutic response and modify treatment when necessary. Consequently, rational pharmacotherapy in this patient population should be understood as a continuous process of assessment, treatment selection, monitoring, and adjustment aimed at achieving symptom control, reducing cardiovascular risk, and maintaining medication safety. Contemporary ESC and AHA/ACC guidance supports this patient-centered approach to chronic coronary disease management.

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