MyCardioAdvocate™

Older Adults & Cardiovascular Risk

When age leads to under-treatment, missed secondary prevention, and preventable events

Updated March 2026

Why This Matters

Aging and cardiovascular disease are not synonymous. An active, cognitively intact 80-year-old with preserved life expectancy and a prior MI deserves secondary prevention (statin, antiplatelet, ACE-I) as much as a 60-year-old does. Yet older adults are systematically under-treated. Physicians perceive higher risk from medications than from recurrent events; families worry about polypharmacy; institutional barriers (short hospital stays, fragmented care) mean that secondary prevention is not initiated or is discontinued. The result: preventable recurrent events, stroke, and death in older adults who would benefit from evidence-based treatment but receive it only inconsistently. Conversely, a frail 85-year-old with cognitive decline and a life expectancy of 1 year benefits little from statin initiation; in this context, less treatment is more. The challenge is distinguishing between them.

Why Older Adult Under-Treatment Flies Under the Radar

Ageism is invisible. Clinicians don't explicitly say 'I won't treat you because you're 80.' Instead, they invoke vague concepts: 'frailty,' 'polypharmacy burden,' 'life expectancy too short.' But life expectancy at 75 is 10+ years; at 80, it's 8+ years. Most of those remaining years are spent without major disability. Also, the evidence base for guideline recommendations often excludes or underrepresents older adults. RCTs of statins, for example, rarely enroll people >75; many exclude people on dialysis, with dementia, or in nursing homes. When evidence is absent, guidelines revert to expert opinion—and expert opinion is biased by individual experience and unconscious assumptions about age. Finally, older adults themselves may accept under-treatment as inevitable, not realizing that secondary prevention would extend quality life expectancy.

What Changed in 2026

- >75 years: Benefit-risk discussion is now the standard.

For patients >75, the 2025 ACC expert consensus and 2026 updates recommend shared decision-making rather than guideline-driven treatment. This is appropriate: the benefit of statin initiation in a 78-year-old takes time to materialize, and competing risks (drug interactions, falls, bleeding) must be weighed. But 'discussion' requires both parties to be informed; many older patients are not offered this conversation at all.

- Time-to-benefit ~2.5 years for primary prevention, longer for secondary.

For a person starting a statin at age 80 with no prior events, the number-needed-to-treat to prevent one event is high, and the time horizon is years. For someone 80 with a prior MI, the equation shifts: they have already had an event, and recurrent risk is higher. Secondary prevention is justified; the question is intensity, not initiation.

- CAC score = 0 may support deferring primary prevention.

An asymptomatic 78-year-old with CAC = 0 has very low 10-year risk; guideline-based therapy is less urgent. Conversely, CAC >100 in the same age group strengthens the case for therapy, even if other risk factors are borderline.

- Life expectancy <1 year: Reasonable to discontinue statin therapy (COR 2b).

Statins take years to prevent events; if the patient is expected to live <1 year, the benefit is negligible and burden is real. Having this conversation explicitly—'Based on your health, we estimate you might live another X years. For a statin to help prevent a heart attack or stroke, we'd need at least that much time'—is humane and evidence-based.

MyCardioAdvocate™ Checklist

1. Clarify your risk category (primary vs. secondary prevention)

Have you had a prior MI, stroke, or unstable angina? If yes, secondary prevention is standard and your age alone should not change the recommendation. If no, clarify: Am I at high risk (hypertension, diabetes, family history)? The approach differs fundamentally.

2. Review statin therapy explicitly

If you're on a statin, ask: Why am I on this? Is it primary or secondary prevention? For how long has it been planned? If you're not on one but your doctor suggests it, ask about time-to-benefit and your life expectancy: 'How many years would I need to see a benefit?' If the answer is 5+ years and you're unsure about your lifespan, that should prompt shared decision-making.

3. Address residual risk

After LDL-C is treated, other risk factors matter: BP control, kidney function, heart failure risk, bleeding risk (for antiplatelet therapy). Ask: What other cardiovascular risks do I have, and how are we managing them? A patient with treated LDL-C but uncontrolled hypertension is not optimally managed.

4. Medication reconciliation after hospitalization

After an ED visit or hospitalization, medications are often changed, stopped, or duplicated. Request a medication review (ask your pharmacist or geriatrician). Secondary prevention medications (statin, aspirin, ACE-I) may be inappropriately discontinued. Verify that necessary medications are active and doses are appropriate.

5. Blood pressure and kidney protection

In older adults, the target BP is often individualized (130–140 vs. <130). Ask: What is my target? Why? For kidney protection, an ACE-I or ARB is often appropriate even for primary prevention if you have CKD or albuminuria. Make sure kidney function is monitored (creatinine, eGFR).

6. Functional health status matters

Are you able to perform activities of daily living (bathing, dressing, walking, toileting)? Can you manage your medications? Are you cognitively intact? These factors should inform treatment intensity. A person with advanced dementia or severe disability may prioritize comfort over event prevention; a person who is independent should be treated as an independent adult, regardless of age.

CPR Opportunity: Statin Initiation vs. Continuation in Frail Elderly

The Question: Should an 82-year-old who has been on a statin for 20 years continue it? What about a new diagnosis in an 80-year-old?

Why It Matters: The decision to CONTINUE a statin is different from the decision to INITIATE. Continuation benefits from the fact that the patient has already tolerated 20 years without side effects, and stopping a secondary prevention medication is rarely wise. Initiation in a new patient is different: benefit takes years, risk from drug interactions is real, and the patient's remaining lifespan is uncertain.

Shared Decision-Making Requires: (1) Honest assessment of life expectancy (not 'you're 82 so you'll die soon,' but realistic data about functional life remaining); (2) Time-to-benefit for the specific intervention; (3) Drug interaction and fall risk specific to the patient's other medications; (4) Whether the goal is preventing events or optimizing function and comfort. Both approaches can be evidence-based. The question is which one fits YOUR values.

On the Horizon

- Refined life expectancy calculators that account for functional status, not just age
- Biomarkers of frailty to improve risk stratification in older adults
- Head-to-head trials of treatment intensity (moderate vs. high-intensity statin) in older cohorts
- Integration of geriatric assessment into cardiovascular guidelines

Key Takeaways

- **Age ≠ contraindication.** An active 85-year-old with prior MI benefits from secondary prevention.
- **Context matters: secondary prevention differs from primary.** Prior events change the calculus.
- **Life expectancy is individual, not determined by age alone.** A 75-year-old jogger has a different prognosis than a 75-year-old with multiple comorbidities.
- **Shared decision-making is the standard for >75 years.** You deserve a conversation, not a guideline applied by rote.

Next Steps & Related Content

- If age has been cited as a reason not to treat, ask: Is my risk from disease or from treatment higher?
- Request a medication review with your pharmacist or geriatrician
- Get your life expectancy estimated using a validated tool (e.g., ePrognosis)
- For any new recommendation after age 75, ask: What is my life expectancy, and how long until this treatment helps me?
