Demographics of patients with heart failure who were over 80 years old and were admitted to the cardiology clinics in Turkey

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ABSTRACT

Objective: Heart failure (HF) has a high prevalence and mortality rate in elderly patients; however, there are few studies that have focused on patients older than 80 years. The aim of this study is to describe and compare the age-specific demographics and clinical features of Turkish elderly patients with HF who were admitted to cardiology clinics.

Methods: The Epidemiology of Cardiovascular Disease in Elderly Turkish population (ELDER-TURK) study was conducted in 73 centers in Turkey, and it recruited a total of 5694 patients aged 65 years or older. In this study, the clinical profile of the patients who were aged 80 years or older and those between 65 and 79 years with HF were described and compared based on the ejection fraction (EF)-related classification: HFrEF and HFpEF (is considered as EF: ≥50%).

Results: A total of 1098 patients (male, 47.5%; mean age, 83.5±3.1 years) aged ≥80 years and 4596 patients (male, 50.2 %; mean age, 71.1±4.31 years) aged 65-79 years were enrolled in this study. The prevalence of HF was 39.8% for patients who were ≥80 years and 27.1% for patients 65–79 years old. For patients aged ≥80 years with HF, the prevalence rate was 67% for hypertension (HT), 25.6% for diabetes mellitus (DM), 54.3% for coronary artery disease (CAD), and 42.3% for atrial fibrillation. Female proportion was lower in the HFrEF group (p=0.019). The prevalence of HT and DM was higher in the HFpEF group (p<0.01), whereas CAD had a higher prevalence in the HFrEF group (p=0.02). Among patients aged 65–79 years, 43.9% (548) had HFpEF, and 56.1% (700) had HFrEF. In this group of patients aged 65-79 years with HFrEF, the prevalence of DM was significantly higher than in patients aged ≥80 years with HFrEF (p<0.01).

Conclusion: HF is common in elderly Turkish population, and its frequency increases significantly with age. Females, diabetics, and hypertensives are more likely to have HFpEF whereas CAD patients are more likely to have HFrEF. (Anatol J Cardiol 2019; 21: 196-205)

Keywords: epidemiology, heart failure, elder patients

Introduction

Heart failure (HF) is a leading cause of cardiovascular mortality and morbidity, and it is associated with high costs that are burdening health care systems (1). Approximately 6.5 million adults suffer from HF in the United States (2). According to data from the Heart Failure Prevalence and Predictors in Turkey (HAPPY) study, the estimated prevalence of HF is 2.9% in Turkey, which means that 2.000.424 Turkish adults have HF (3). This huge population needs age-specific prudent care to decrease the burden of the disease in Turkey.

The incidence and prevalence of HF gradually increase with advanced age. The number of elderly patients is also increasing in our population. Nearly 8.6% of total population is aged ≥85 years in Turkey (4). Furthermore, as the population gets older, the prevalence of HF continues to increase (5). This is due to progressive aging of the population, as well as the improvements in the HF survival over the years. In addition to its high prevalence, the disease also has a poor prognosis and high mortality rate in elderly patients. The 5-year mortality rate for 80-year-olds with HF is as high as 54.4% (2). Although HF has a markedly high mortality rate and prevalence in the elderly, few studies have focused on patients with HF who are older than 80 years. In large
clinical trials, this growing population is underrepresented or excluded. However, patients aged ≥80 years show a different clinical profile when compared with younger patients. Patients aged ≥80 years with HF have a complex comorbidity and a high number of cardiovascular risk factors, which have a significant impact on the prognosis of the disease (6). Moreover, the effective treatment of chronic cardiovascular disorders, such as coronary artery disease (CAD), hypertension (HT), and diabetes mellitus (DM), may prevent the progression of HF.

Traditionally, HF has been defined as failure of the contractile function of the left ventricle. However, it is recognized that the HF symptoms can occur in the presence of normal or near-normal EF, which is defined as HF with preserved ejection fraction (HFrEF). HFrEF and HFrEF have different clinical characteristics and prognostic factors. Patients with HFrEF are more often female and are more likely to have HT but less likely to have CAD. A recent meta-analysis suggests that patients with HFrEF may have a lower mortality rate than those with HFrEF (7). Although all these differences are well known to affect the prognosis and the clinical outcome of elderly patients with HF, there is not much evidence, especially considering those issues related to specific characteristics of the elderly with HFrEF and HFrEF. Further studies are required to determine specific clinical characteristics of patients aged ≥80 years with HFrEF and HFrEF to produce a contemporary management strategy. The objective of this study is to determine clinical characteristics and major comorbidities of Turkish patients aged ≥80 years with HFrEF and HFrEF, and to compare them with patients aged 65-79 years.

**Methods**

**Study design**

In this study, we used data of 5694 patients aged ≥65 years who were recruited from the ELDER-TURK study, which was conducted in 73 volunteering hospital cardiology clinics participating in 12 EUROSTAT NUTS1 regions of Turkey (Fig. 1, Table 1). The design and details of this study have been reported before (8-10).

In this population-based study, patients aged ≥65 years who were admitted to outpatient cardiology clinics and inpatient wards of state, university, private, and training and research hospitals between March 2015 and December 2015 were included after signing the informed consent for data sharing. In this study, elderly patients from the ELDER–TURK population with known HF (n=1681, 29.5%) were evaluated. As there is no specific classification cutoffs for elderly patients, in this study, participants aged ≥80 years were defined as being of an advanced age. The participants with HF were divided into two groups patients aged 65-79 years (n=1248) and patients aged ≥80 years (n=433). Cardiovascular diseases, risk factors, comorbidities, demographic characteristics, and the laboratory findings were analyzed and compared.

The study was approved by the Local Ethics Committee and conducted according to the principles of the Declaration of Helsinki (as revised in Brasil, 2013).

The diagnosis of HF was established if the following HF symptoms were found: dyspnea, paroxysmal nocturnal dyspnea, and signs of pulmonary and/or peripheral congestion (11). Left ventricular (LV) function was determined by two-dimensional transthoracic echocardiography, which was performed by a physician in all subjects participating in the study. Patients with HF signs and symptoms and a normal or mildly reduced LV systolic function (LVEF >50%) with relevant structural heart disease (left atrial enlargement, LV hypertrophy) and/or diastolic dysfunction were classified as having HFrEF. Patients with HF symptoms and a reduced LV systolic function (LVEF ≤50%) were classified as having HFrEF (12).

Cardiovascular diseases, risk factors, and comorbidities were recorded according to the self-reported history or hospital medical records.

The diagnosis of HF was established by the local investigators by combining information about history, clinical data, medications, and echocardiography. To be eligible for inclusion in the studies, patients were required to have a history of shortness of breath on minimal exertion or at rest [New York Heart Association (NYHA) Class III or IV], within the last month and had to be in NYHA Class II–IV at the time of randomization. Patients were also required to have been treated with a diuretic. The diagnosis of HF was established by the local investigators by combining information about history, clinical data, medications, echocardiography. To be eligible for inclusion in the studies, patients were required to have a history of shortness of breath on minimal exertion or at rest (NYHA Class III or IV), within the last month and had to be in NYHA Class II–IV at the time of randomization. Patients were also required to have been treated with a diuretic.

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| Table 1. List of participating centers and NUTS1 regions | Percentage (%) of total patient population | Percentage (%) of total Turkish population |
|--------------------------------------------------------|-------------------------------------------|------------------------------------------|
| 1) İstanbul                                            |                                           |                                          |
| Pendik State Hospital                                  | 398                                       |                                          |
| Şişli Etfal Training and Research Hospital             | 231                                       |                                          |
| Kartal Koşuyolu Yüksek İhtisas Training and Research Hospital | 208                                       |                                          |
| Okmeydanı Training and Research Hospital               | 94                                        |                                          |
| İstanbul University, Cardiology Institute              | 83                                        |                                          |
| GATA Haydarpaşa                                        | 77                                        |                                          |
| İstinye State Hospital                                 | 75                                        |                                          |
| Türkiye Hospital/Memorial Hospital                     | 43                                        |                                          |
| Surp Pirgic Ermeni Training and Research Hospital       | 17                                        |                                          |
| Medipol University Faculty of Medicine                 | 5                                         |                                          |
| Mehmet Akif Ersoy Training and Research Hospital        | 40                                        |                                          |
| Total                                                  | 1271                                      | 22.32                                    |
| 2) West Anatolia                                       |                                           |                                          |
| Mevlana University Faculty of Medicine                 | 104                                       |                                          |
| Seçuk University Faculty of Medicine                   | 31                                        |                                          |
| Başkent University Faculty of Medicine                 | 41                                        |                                          |
| Gazi University Faculty of Medicine                    | 15                                        |                                          |
| GATA Ankara                                            | 41                                        |                                          |
| Türkiye Yüksek İhtisas Training and Research Hospital  | 428                                       |                                          |
| Hacettepe University Faculty of Medicine               | 87                                        |                                          |
| Ankara University Faculty of Medicine                  | 40                                        |                                          |
| Keçiören Training and Research Hospital                | 43                                        |                                          |
| Yenimahalle Training and Research Hospital             | 234                                       |                                          |
| Ereğli State Hospital                                 | 1                                         |                                          |
| Turgut Özal University Faculty of Medicine             | 4                                         |                                          |
| Total                                                  | 1069                                      | 18.77                                    |
| 3) East Marmara                                        |                                           |                                          |
| Sakarya Training and Research Hospital                 | 9                                         |                                          |
| Total                                                  | 9                                         | 0.15                                     |
| 4) Egean Region                                        |                                           |                                          |
| Ege University Faculty of Medicine                     | 366                                       |                                          |
| Muğla Sıtkı Koçman University Faculty of Medicine      | 142                                       |                                          |
| Muğla Yücelen Private Hospital                         | 127                                       |                                          |
| Menemen State Hospital                                 | 74                                        |                                          |
| Manisa State Hospital                                  | 61                                        |                                          |
| Gazi Emir State Hospital                               | 44                                        |                                          |
| Aksaz Military Hospital                                | 40                                        |                                          |
| Denizli State Hospital                                 | 40                                        |                                          |
| Denizli Server Gazı State Hospital                     | 40                                        |                                          |
| Kemalpaşa State Hospital                               | 40                                        |                                          |
| Kent Hospital                                          | 40                                        |                                          |
| Location                                                                 | Percentage of Total Patient Population | Percentage of Total Turkish Population |
|-------------------------------------------------------------------------|----------------------------------------|----------------------------------------|
| İzmir Tepecik Training and Research Hospital                            | 38                                     |                                        |
| Manisa Demirci State Hospital                                           | 24                                     |                                        |
| İzmir Military Hospital                                                 | 120                                    |                                        |
| Afyon State Hospital                                                    | 114                                    |                                        |
| Bolvadin State Hospital                                                 | 40                                     |                                        |
| Afyon Kocatepe University Faculty of Medicine                           | 8                                      |                                        |
| Total                                                                   | 1358                                   | 23.84                                  | 17.63                                  |
| 5) West Marmara                                                         |                                        |                                        |
| Edirne State Hospital                                                   | 7                                      |                                        |
| Tekirdağ State Hospital                                                | 60                                     |                                        |
| Namik Kemal University Faculty of Medicine                              | 46                                     |                                        |
| Total                                                                   | 113                                    | 1.98                                   | 1.46                                   |
| 6) Mediterranean                                                        |                                        |                                        |
| Antalya Atatürk State Hospital                                         | 137                                    |                                        |
| Tarsus State Hospital                                                   | 126                                    |                                        |
| Akdeniz University Faculty of Medicine                                  | 120                                    |                                        |
| Mustafa Kemal University Training and Research Hospital                 | 65                                     |                                        |
| Necip Fazıl State Hospital                                              | 57                                     |                                        |
| Antalya Training and Research Hospital                                  | 55                                     |                                        |
| Antakya Defne Private Hospital                                          | 40                                     |                                        |
| Isparta State Hospital                                                  | 19                                     |                                        |
| Süleyman Demirel University Faculty of Medicine                         | 1                                      |                                        |
| Antalya OFM Private Hospital                                            | 2                                      |                                        |
| Mersin University Faculty of Medicine                                  | 8                                      |                                        |
| Osmaniye State Hospital                                                 | 8                                      |                                        |
| Total                                                                   | 638                                    | 11.2                                   | 8.28                                   |
| 7) West Black Sea                                                       |                                        |                                        |
| Samsun Training and Research Hospital                                   | 15                                     |                                        |
| Hitt University Faculty of Medicine                                     | 153                                    |                                        |
| Sinop State Hospital                                                    | 3                                      |                                        |
| Osmangazi University Faculty of Medicine                                | 10                                     |                                        |
| Total                                                                   | 181                                    | 3.17                                   | 2.35                                   |
| 8) Middle Anatolia                                                      |                                        |                                        |
| Ahi Evren Thoracic and Cardiovascular Training and Research Hospital    | 12                                     |                                        |
| Ahi Evren University Training and Research Hospital                     | 219                                    |                                        |
| Aksaray State Hospital                                                  | 62                                     |                                        |
| Total                                                                   | 293                                    | 5.14                                   | 3.8                                    |
| 9) East Black Sea                                                       |                                        |                                        |
| Rize Kaçkar State Hospital                                              | 340                                    |                                        |
| Total                                                                   | 340                                    | 5.97                                   | 4.41                                   |
| 10) Southeast Anatolia                                                  |                                        |                                        |
| Mardin State Hospital                                                   | 91                                     |                                        |
| Siirt State Hospital                                                    | 43                                     |                                        |
| Gaziantep University Faculty of Medicine                                | 11                                     |                                        |
The diagnosis of HF was established by the local investigators by combining information about history, clinical data, medications, and echocardiography. To be eligible for inclusion in the study, patients were required to have a history of shortness of breath on minimal exertion or at rest (NYHA Class III or IV), within the last month and had to be in NYHA Class II–IV at the time of randomization. Patients were also required to have been treated with a diuretic.

Patients were defined as hypertensive if they were using antihypertensive medications or if they had high blood pressure on examination (systolic >140 mm Hg or diastolic >90 mm Hg) (13). Patients who were newly diagnosed as diabetic or who were already using an oral hypoglycemic agent or insulin were reported as diabetic. The glomerular filtration rate (GFR) was calculated using the Modification of Diet in Renal Disease formula. Chronic renal failure (CRF) was defined as an estimated GFR <60 mL/min for at least 3 months (14). Smoking status was recorded as positive if the patients were an active smoker. Patients were considered as having CAD in the presence of previous myocardial infarction, stable or unstable CAD, a history of myocardial revascularization, and coronary artery by-pass graft operation (15).

Statistical analysis

All statistical analyses were performed using the SPSS program, version 21 (Chicago, IL, USA) for Windows XP. Data summary was planned to be shared by tables. Continuous variables were expressed as the mean±standard deviation. The chi-square test was used for categorical variables and was expressed as the number of cases and percentages (%). Mean differences between groups were compared by Student’s t-test, whereas the Mann–Whitney U test was applied for comparisons of the not normally distributed data. Values for p<0.05 were considered to indicate statistical significance.

Results

Among 1089 patients aged ≥80 years (male, 47.5%; mean age, 83.5±3.1 years), 39.8% (433) had HF. The prevalence of CAD and peripheral artery disease (PAD), DM, and atrial fibrillation (AF) were higher in patients aged ≥80 years with HF when compared to those without HF (54.3% vs. 32.3%, 45.5% vs. 14.3%, 25.6% vs. 23%, 42.3% vs. 31.7%, respectively, all p<0.01) whereas the prevalence of HT was higher in patients aged ≥80 years without HF (74.2% vs. 67%, p<0.01). Approximately 9.9% of those patients with HF were smoking (Table 2). The prevalence of comorbidities in very elderly with HF were 25.4% for chronic obstructive pulmonary disease (COPD), 26.8% for anemia, and 19.9% for CRF. There was no age or gender difference between those with HF and without HF. The mean heart rate was significantly higher in patients with HF (76.4±14.3 vs. 80.5±18.5 p<0.01). Laboratory values and demographic characteristics are given in Table 2. Nearly half of those patients with HF had HFrEF (50.1%, 217), and 49.9% (216) had HFpEF. The proportion of females was significantly higher in those with HFpEF (55.1%, 119) (p=0.019). The mean age was similar between the groups (83.8±3.2 vs. 83.7±3.3, p=0.457). When compared with patients aged ≥80 years with HFrEF, the prevalence of HT and DM were higher in those with HFpEF (54.3% vs. 32.3%, 45.5% vs. 14.3%, 25.6% vs. 23%, 42.3% vs. 31.7%, respectively, all p<0.01). Whereas, the prevalence of CAD was significantly higher in patients aged ≥80 years with HFrEF (62.7% vs. 45.8%, p=0.02) (Table 3).

Among 4596 of patients aged 65-79 years (male, 50.2%; mean age, 71.1±4.31 years), 27.1% (1248) had HF. In those patients, the prevalence of HFrEF and HFpEF were 56.1% (700) and 43.9% (548), respectively. In the HFrEF group, DM had a higher frequency in patients aged 65–79 years when compared with patients aged ≥80 years (5.3% vs. 24.1%, p<0.01). Tables 3 and 4 represent...
comparison based on EF-related classification between patients with HF aged ≥80 years and patients with HF aged 65–79 years.

**Discussion**

In this multi-centered, epidemiologic study, a large number of elderly patients with HF who were admitted to cardiology clinics were recruited. Significant epidemiologic data on cardiovascular disease and risk factors among Turkish elderly patients with HF were obtained. We observed significant differences between patients with HF aged 65–79 years and ≥80 years.

The age-specific prevalence of HF among patients aged 75–84 years was 22% in the CARLA study (German), 13% in the ROTTERDAM study (The Netherlands), and 8.4% in the Olmsted county study (USA) (5, 16, 17). In patients aged ≥80 years, the prevalence of HF is 14.1% for males and 13.4% for females in the United States (2). In southwestern Europe, the prevalence of HF for patients aged ≥80 years is 16.14% (18). In those community-based epidemiologic surveys, the prevalence of HF for the elderly population was lower than our finding in cardiology clinics in Turkey.

The prevalence of HFrEF progressively increases with advanced age and grows by 12%–14% in the population aged ≥80 years (19). We observed that nearly half of the very elderly patients with HF had HFrEF in cardiology clinics, which was similar to the other large studies, such as the Framingham and Olmsted county study. In accordance with those large studies, among very elderly patients with HF, CAD was the most contributing factor to HF and was followed by HT (5, 20, 21). CAD is also a strong predictor of all-cause mortality in the elderly (20, 21). In our study, CAD had a higher prevalence in patients aged ≥80 years with HF compared to those without HF.

In the TAKTIK study, the prevalence of CAD for patients hospitalized for acute HF in Turkey was 61% (22). However, our finding was close to results of the EFHS II study (23). In the EFHS II study, the prevalence of CAD in patients aged ≥80 years with HF was 51%, which is similar to our result. This observed difference between the studies might be due to the age distribution of study populations. The prevalence of cardiovascular comorbidities depends on age, but the relationship is not linear. All cardiovascular comorbidities gradually increase until the age of 80 years and then decrease (24, 25). In the EFHS II study, the mean age was similar to the one in our study; however, the mean age was lower in the TAKTIK study (62±13). As a consequence, the prevalence of CAD seems to be higher in the TAKTIK study. Nevertheless, the ELDER–TURK study includes both outpatient cardiology clinics and inpatient wards, which might have an impact on these reported different results.

As CAD is a predominantly caused by HF and has a higher prevalence in very elderly with HF, prevention of the onset of CAD is the key to reducing the burden of HF in cardiology clinics in Turkey. In our study, most of cardiovascular disease risk factors and comorbidities such as CAD, DM, PAD, AF, and anemia were higher in very elderly patients with HF, as shown in Table 3.
In contrast to EHFS II, the prevalence of HT in patients aged ≥80 years with HF was not statistically different than the patients aged 65–79 years with HF. In our study, the mean systolic blood pressure (SBP) was lower in very elderly patients with HF compared to those without HF, which means very elderly patients with HF were more hypotensive. This means those patients should be monitored more closely in cardiology clinics, and aggressive antihypersensive treatment should be avoided in those patients.

In very elderly with HFrEF, the proportion of females was higher, which was similar to large studies such as MAGGIC, HAPPY, PREFER, and CHARM (3, 7, 26, 27). In the CARLA study, single strongest determinant for HFrEF was HT, and this result was similar to our study; HT had a higher prevalence in very elderly patients with HFrEF compared to those with HFrEF. On the other hand, in accordance with the OPTIMIZE-HF; registry the frequency of DM was higher in patients with HFrEF compared to those with HFrEF (26). Very elderly patients with HFrEF were found to be older than patients with HFrEF in some studies that do not consider patients aged ≥80 years. However, in our study, there was no age difference between very elderly patients with HFrEF and HFrEF (28, 29). The prevalence of DM in patients aged ≥80 years with HFrEF was lower than in patients aged 65–79 years with HFrEF. This result was consistent with the EHFS I and II studies. This may be related to reduced likelihood of surviving in older patients with DM compared to those without DM.

One of the predictors of all-cause mortality in patients aged ≥70 years with HF is PAD (21). In this study, PAD was significantly higher in very elderly with HF compared to those without HF.

AF has a great prognostic importance with regard to long-term mortality in very elderly with HF (30). In our study, the prevalence of AF was lower in very elderly with HF compared to those without HF. This may be a satisfactory result for a better long-term survival in very elderly with HF in Turkey. In the EFHS II study, the prevalence of AF was 48% in patients aged ≥80 years with HF, and this was also close to our result (23).

Smoking status should also be questioned and identified in cardiology clinics. The prevalence of smoking for very elderly with HF was as high as for those without HF in our study. The cardiologist should be focused more on smoking-cessation efforts for primary care in those patients. Smokers need to be identified and offered pharmacological or behavioral smoking-cessation support. Moreover, guidelines should focus on smoking cessation for very elderly with HF.

In our study, the prevalence of COPD in very elderly with HF was higher than in the EHFS II study (23), whereas the prevalence of renal failure was similar with the HAPPY cohort (25). Renal failure is a strong predictor of both in-hospital mortality and follow-up mortality (31). In our study, the mean creatinine value was significantly higher in very elderly with HF, which may be associated with poor outcome.

### Study limitations

This study included only patients who were admitted to outpatient cardiology clinics and inpatient wards. Hence, the prevalence of HF is higher than in the population-based studies. This is thought to be the cause of selection bias and is one of the study limitations.

Very elderly who were followed up at outpatient wards were less frail and were functioning better, and we believe that this led to underestimated prevalence of cardiovascular disease and risk factors. In addition, some comorbidities lead to a reduced survival rate. This could also have caused underestimated prevalence of CAD and risk factors, such as DM.

### Conclusion

In this study, we provide a national database about the prevalence of cardiovascular diseases, risk factors, and comorbidities of a large population of Turkish elderly patients with HF and compare it with other large studies. Despite the high prevalence of comorbidities and risk factors, there is no evidence-based therapy for the treatment of very elderly with HF. Consequently, there is a need to develop more effective and targeted management strategies for this population.
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