

Telematic cardiology consultation in the elderly. The 5 M framework can help. Response



Consulta telemática de cardiología para ancianos. La regla de las 5 M puede ser una ayuda. Respuesta

To the Editor,

We appreciate the letter from Díez-Villanueva et al. regarding the consensus document of the Spanish Society of Cardiology (SEC) on telematic consultation. The authors stress the special characteristics of the geriatric population, whose peculiarities are well-known to clinical cardiologists, given that many of the patients we treat in the clinic are elderly. Accordingly, although there is no explicit reference to the elderly population in the document, the information provided is applicable to older patients.

The authors propose the use of the 5 M framework. While published before the COVID-19 pandemic, this system may have even greater validity now. Although the framework has practical usefulness, its value is not exclusively limited to the elderly population. Indeed, some of the “Ms” are pillars of the telematic consultation, independently of age, as described in the consensus document. However, the first “M” is unfortunately not very intuitive in Spanish (translated from “Matters Most to Me” as “*Más importante*” [“More important”]) and its significance is thus less memorable.

A point highlighted by the authors is the need to help elderly people, who are typically cut off from new technologies, to understand telemedicine. Although this aspect is undeniable, we must also recognize that, in the face of the sudden proliferation in computing technology, we have witnessed an astonishing adaptive capacity of our elderly population. Many have progressed with an unexpected ease from using their mobile phone to just make phone calls to writing messages on WhatsApp and even videoconferenc-

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ing. Nonetheless, we agree that their difficulties must be understood to allow us to take advantage of telemedicine opportunities and to facilitate the use of the tools available to overcome possible limitations with the new technologies, as has recently been discussed.^{1,2}

The treatment of elderly cardiology patients is an essential component of the cardiology consultation.³ Accordingly, all contributions from experts in geriatrics are welcome to promote cooperation and collaboration between professionals and directly improve the care of older patients.

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Typical angina, atypical angina, and atypical chest pain: is it time to change this terminology?



Angina típica, angina atípica y dolor torácico atípico: ¿es hora de cambiar esta terminología?

To the Editor,

The latest guidelines of the European Society of Cardiology on chronic coronary syndromes were recently published in *Revista Española de Cardiología*, together with an editorial comment.^{1,2} We noticed that, in the section referring to the evaluation of patients with chest pain, the guidelines continue to classify this symptom as typical angina, atypical angina, and atypical chest pain. This taxonomy was introduced many years ago for the systematic diagnosis of patients³ and, with some modifications, has since been widely used. It is also included in the American guidelines.⁴ However, we believe it to have major limitations, with its strict application possibly even resulting in erroneous clinical decisions. As noted by the authors of the

guidelines,^{1,4} it has limited ability to identify patients with coronary heart disease: on the one hand, a large proportion of patients with ischemic heart disease—particularly women, elderly patients, and patients with comorbidities—do not have typical angina and, on the other, patients who do have it often have no coronary lesions or observable ischemia.

Accordingly, when evaluating patients to determine whether their symptoms are due to myocardial ischemia, we must remember that “typical angina” is not pathognomonic for ischemic heart disease and, more importantly, that “atypical chest pain” does not rule it out. For example, epigastric pain clearly related to exertion should be considered atypical due to its location but indicates angina. Moreover, crushing chest pain that appears exclusively at rest cannot be considered atypical angina, despite being highly suggestive of vasospastic angina if the crises occur at night and are brief. In addition, this classification is focused on ischemic heart disease and fails to consider other cardiac and noncardiac causes of chest pain. For example, chest pain clearly related to respiratory movement is atypical of angina but typical of pericarditic or pleuritic pain, whereas a sudden and severe pain in

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the interscapular region is atypical of angina but typical of acute aortic syndrome.

In our opinion, it would be more useful from the clinical point of view to use a less categorical terminology, such as chest pain that is “highly suggestive”, “suggestive”, “compatible”, or “not very suggestive” of angina or chest pain that is “suggestive” of pericarditis, pleurisy, acute aortic syndrome, or chest wall pain. Taken together with the pretest probability of ischemic heart disease or of other thoracic conditions, this approach would have clear clinical usefulness to guide diagnosis and to indicate the most appropriate tests. Sometimes, the pain might not indicate any particular disease: we believe that, in this case, the most appropriate term would be “nonspecific chest pain, without evidence of specific disease”. We are aware that the terms “typical angina”, “atypical angina”, and “atypical chest pain” are deeply ingrained but we believe that our proposed nomenclature is more useful and better suited to current clinical practice. When treating patients with chest pain, clinicians usually make a judgment on the most probable diagnosis based on their knowledge and experience, rather than relying on an algorithm. Even some studies of proven scientific quality⁵ have relied more on physicians’ subjective interpretation of symptoms than on the abovementioned taxonomy.

Finally, as cardiologists, although we are used to assessing chest pain through the prism of ischemic heart disease and pericardial or aortic conditions, other structures in the chest can cause pain. Our proposed terminology avoids this possible bias and is applicable to all causes of chest pain.

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