



Tori-No AIDS 2025: incontri con l'esperto su HIV

**Giovedì 11 settembre ore 18:15
sala polivalente
Vol.To, Via Giolitti, 21 - Torino**

INVECCHIARE IN SALUTE: ISTRUZIONI PER L'USO

Relatore: prof. Mario Bo
Direttore SCU Geriatria, Università di Torino

Moderatore: dr. Pietro Altini
Presidente ARCOBALENO Aids ODV

Per informazioni: 3517552585 - arcobalenoidsto@gmail.com



60 years of healthy aging: On definitions, biomarkers, scores and challenges

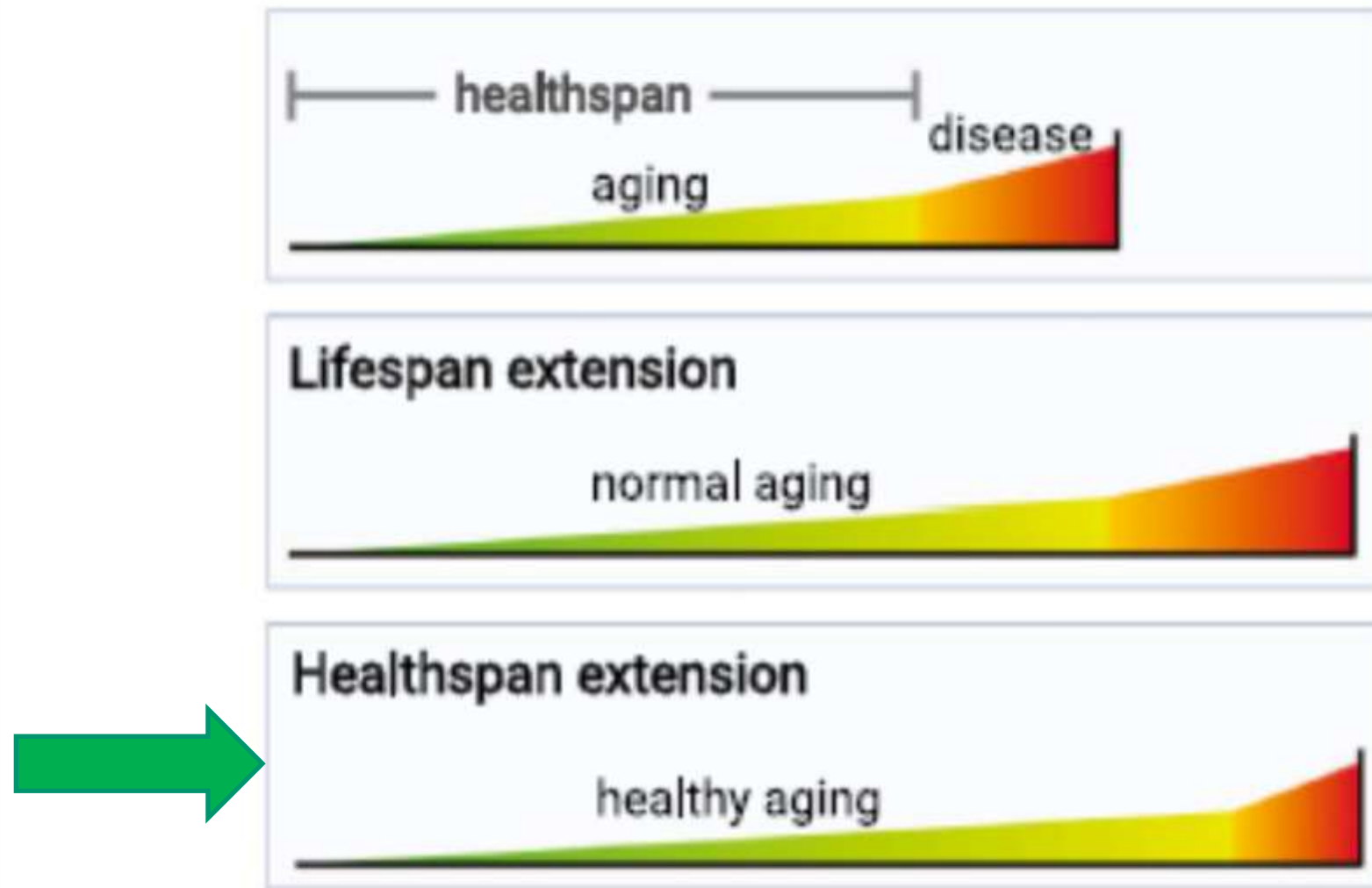
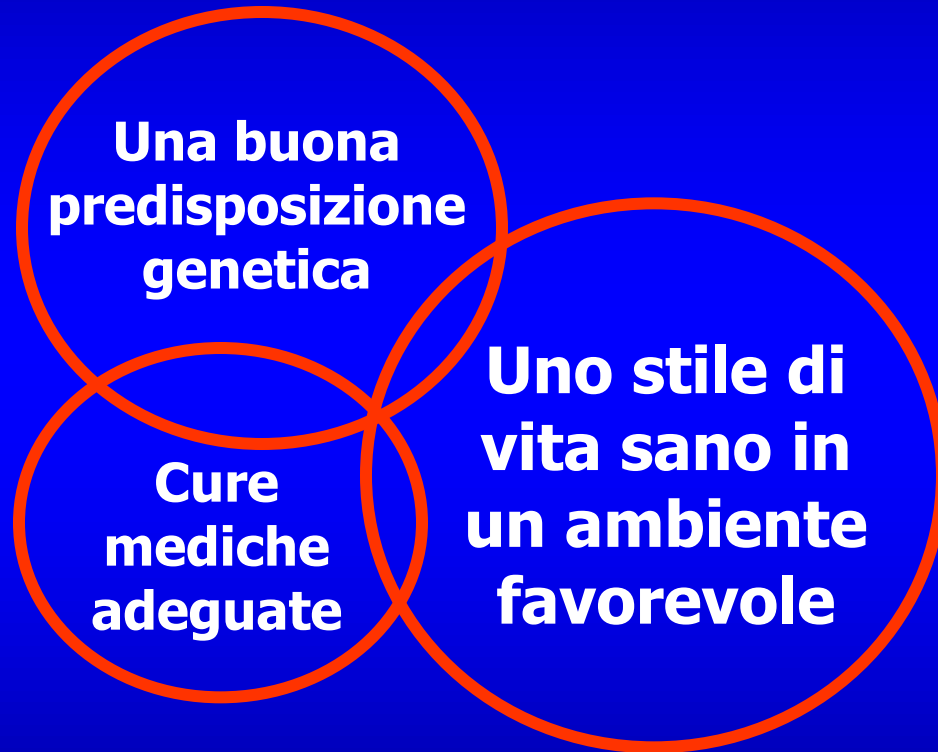


Fig. 2. : Lifespan and healthspan extension in healthy aging.

In summary, we believe that the results of our review indicate accelerated epigenetic ageing in PLWH compared to uninfected individuals. However, it should be noted that the detailed results of previously published studies differ in many aspects, which may be related to the different methods used in individual studies and the above-described limitations. We believe that further studies taking into account the above-described confounding factors are needed. In particular, studies considering the impact of individual classes of antiretroviral drugs, the age of the patient at the time of HIV diagnosis, and the timeliness of diagnosis on the acceleration of epigenetic ageing are needed.

Che cosa serve per invecchiare in buona salute cardiovascolare?



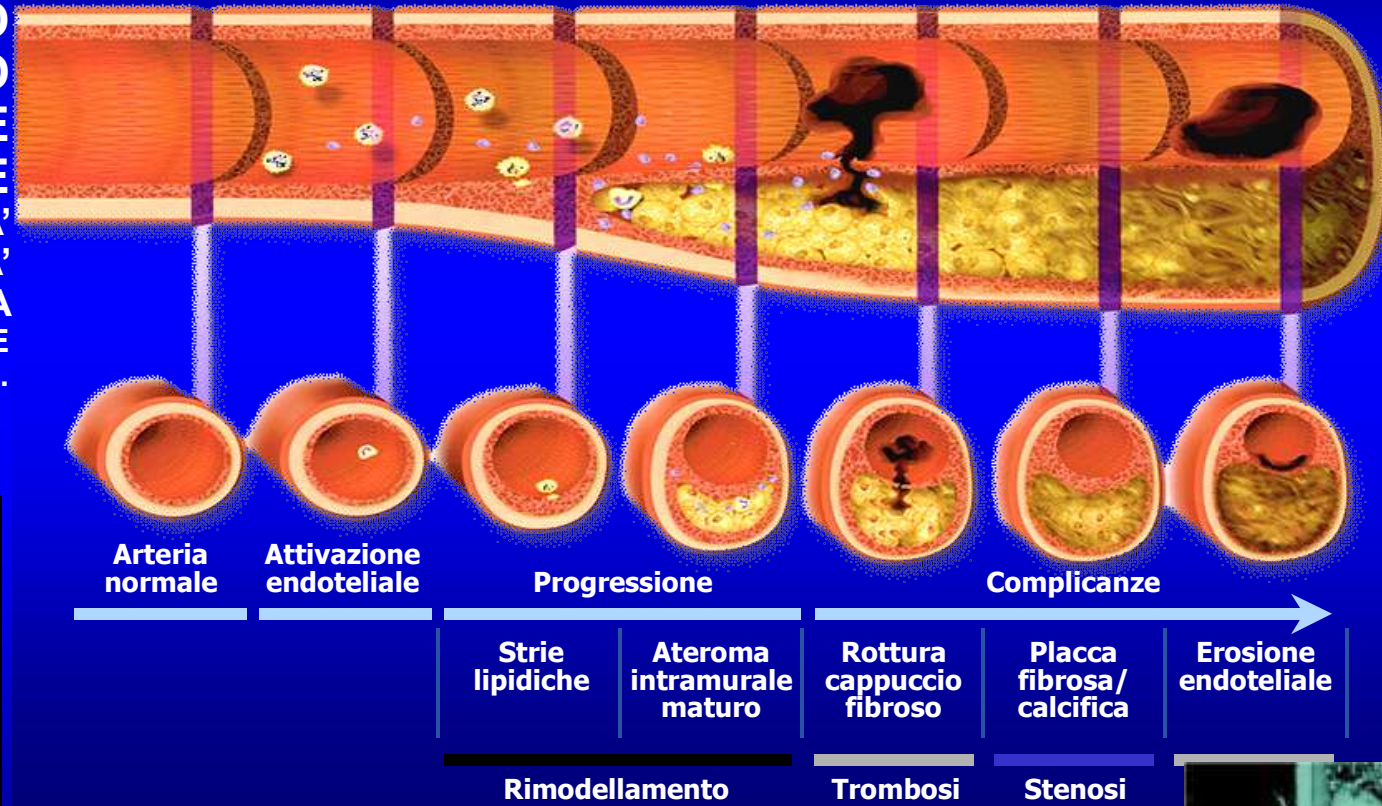


ETA'
SESSO
FAMILIARITA'



LA STORIA NATURALE DELL'ATEROSCLEROSI

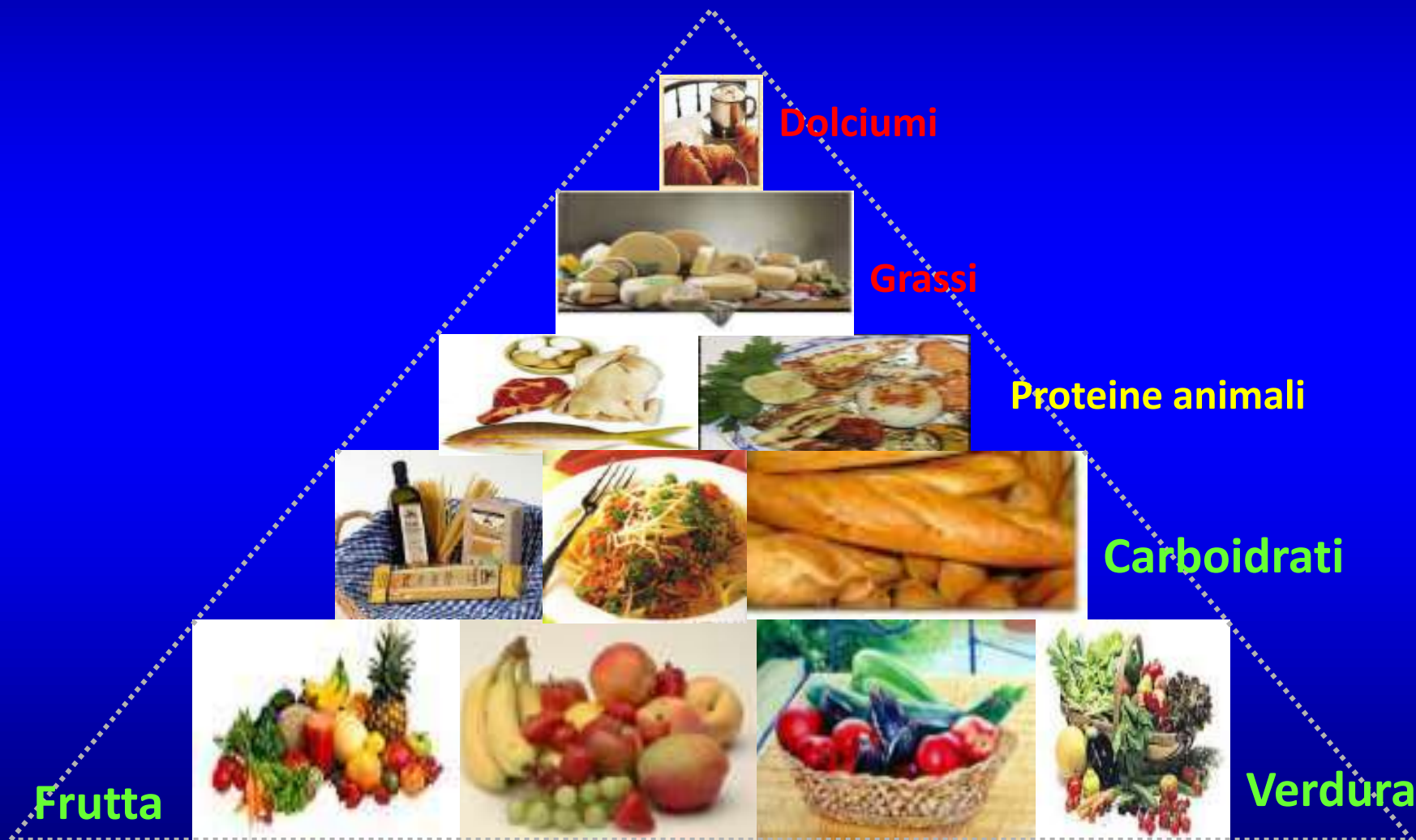
IPER-COLESTEROLO
FUMO
DIABETE
IPERTENSIONE
OBESITA'
SEDENTARIETA'
S.METABOLICA
INFIAMMAZIONE
IPERCOAGULABILITA'...



NEJM, 1999.



The Mayo Clinic Healthy Weight Pyramid



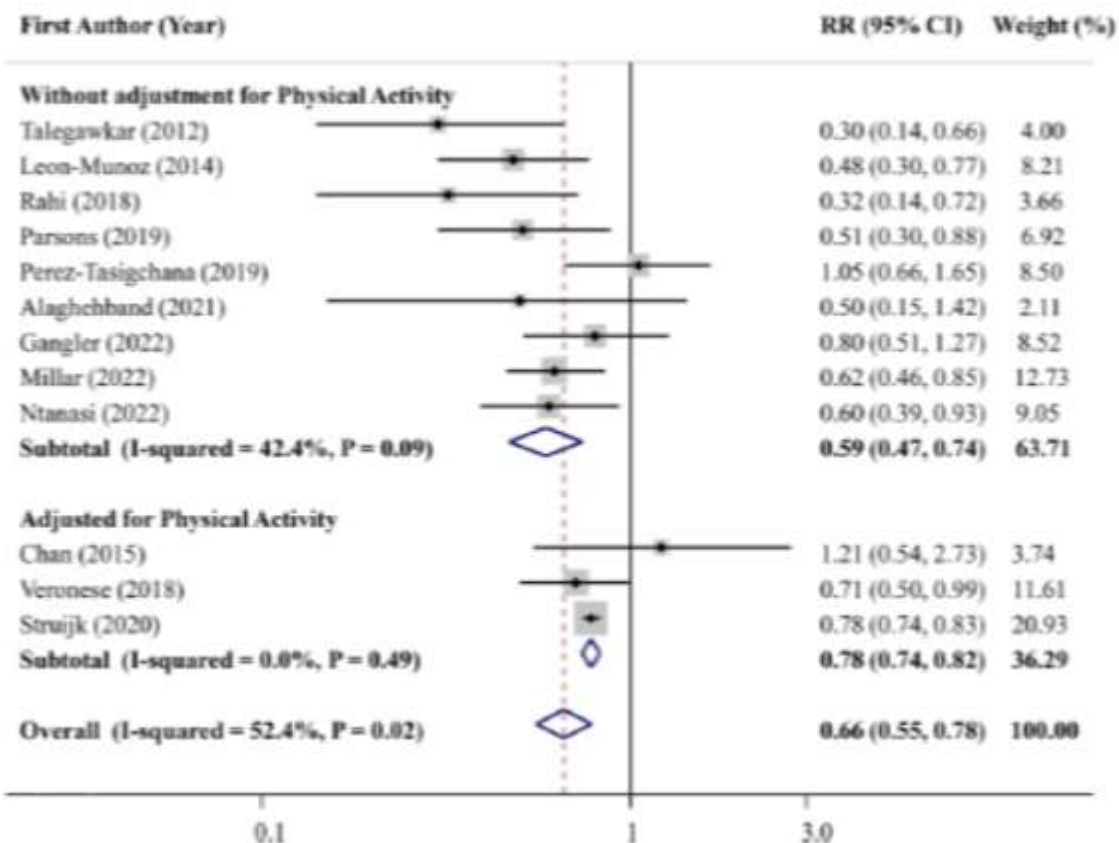
**The Polymeal: a more natural, safer, and probably tastier
(than the Polypill) strategy to reduce cardiovascular
disease by more than 75%**

Oscar H Franco, Luc Bonneux, Chris de Laet, Anna Peeters, Ewout W Steyerberg,
Johan P Mackenbach

	Ingredienti	Riduzione percentuale (95% CI) rischio CV
	Vino (150 ml/giorno)	32 (23-41)
	Pesce (114 gr quattro volte/settimana)	14 (8-19)
	Cioccolato amaro (100 gr/giorno)	21 (14-27)
	Frutta e verdura (400 gr/giorno)	21 (14-27)
	Aglione (2.7 gr/giorno)	25 (21-27)
	Mandorle/noci (68 gr/giorno)	12.5 (10.5-13.5)
	Effetto totale	76 (63-84)

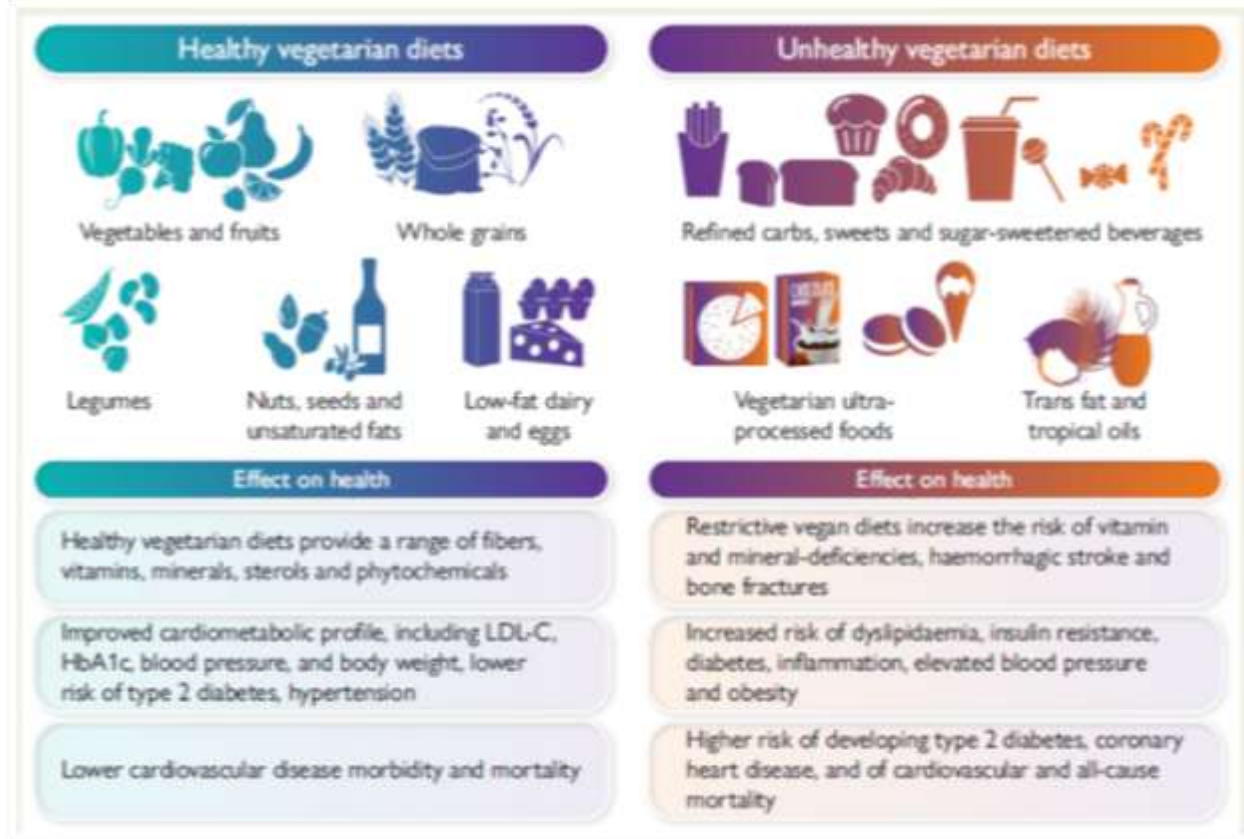
Adherence to the Mediterranean diet and risk of frailty and pre-frailty in elderly adults: A systematic review and dose-response meta-analysis with GRADE assessment

Ageing Research Reviews 87 (2023) 101903



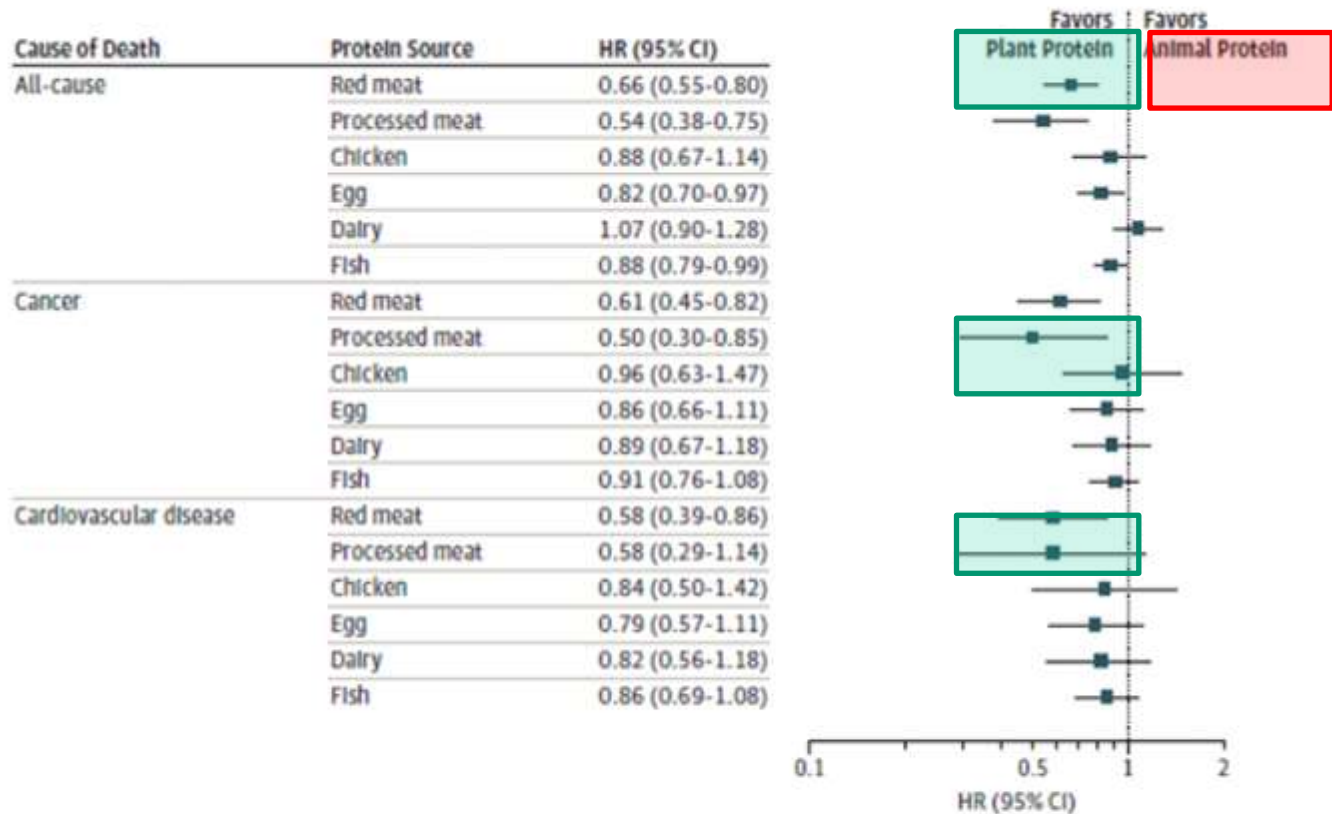
A highest vs. lowest analysis of Mediterranean diet and risk of frailty based on adjustment for physical activity in prospective cohort studies.

Vegetarian and vegan diets: benefits and drawbacks



European Heart Journal (2023) 44, 3423–3439

Figure 1. Hazard Ratios (HRs) for Mortality Associated With Isocaloric Substitution of 3% Energy From Plant Protein for Animal Protein From Various Sources



Model includes plant protein and the various sources of animal protein and is adjusted for total energy, percentage of energy from fats (saturated, monounsaturated, polyunsaturated, and other) and carbohydrates (all continuous), age (≤ 50 , 51-55, 56-60, 61-65, 66-70, or ≥ 70 years), sex, body mass index (calculated as weight in kilograms divided by the height in meters squared; < 22.5 , 22.5 to < 25.0 , 25.0 to < 27.5 , or ≥ 27.5), smoking (never, past, or current with

≤ 20 or > 20 cigarettes per day), alcohol use (none or occasional or regular ethanol consumption of < 150 , 150 to < 300 , or ≥ 300 g per day), physical activity (quartile category in metabolic equivalent hours per day), occupation status (agriculture/forestry/fishery, salaried/professional, self-employed, housework/unemployed, or other), and intake of green tea (never, < 1 , 1, 2-3, or ≥ 4 cups per day) and coffee (never, < 1 , 1, or ≥ 2 cups per day).

ORIGINAL INVESTIGATION

Alcohol Consumption and Cardiovascular Disease Mortality in Hypertensive Men

Rischio di morte per cause specifiche in coloro che riferiscono consumo **mensile**, **settimanale** o **giornaliero** di bevande alcoliche rispetto a soggetti che non bevono mai bevande alcoliche

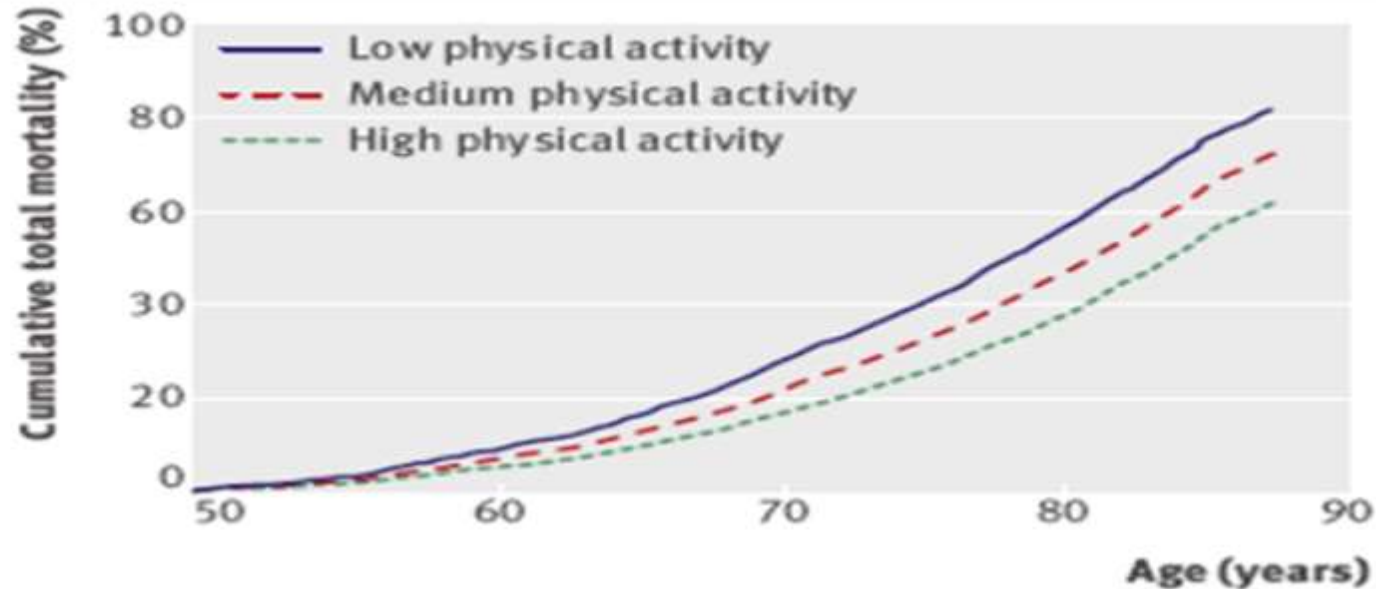
	mensile	settimanale	giornaliero	
Mortalità CV	0.83 (0.62-1.13)	0.61 (0.49-0.77)	0.56 (0.44-0.71)	P<.001
Mortalità totale	0.86 (0.67-1.10)	0.72 (0.60-0.86)	0.73 (0.61-0.87)	P<.001
Mortalità CV in ipertesi	0.82 (0.56-1.21)	0.64 (0.48-0.85)	0.56 (0.42-0.75)	P<.001



- Cerca di nascere in una famiglia con una predisposizione alla longevità
- Non fumare!
- **Fai movimento o sport solo nei giorni nei quali mangi...**
- Evita le diete troppo rigorose
- Segui una dieta sana (mediterranea)
- Cerca di non ingrassare
- Sii moderato nell'apporto di alcolici
- Consulta periodicamente il tuo medico per un'adeguata prevenzione
- Coltiva le amicizie e le gioie della famiglia...evita persone o compagnie che ti sono sgradite
- Coltiva hobbies o interessi al di fuori dell'ambito lavorativo
- Mantieniti informato, ma evita di farti stressare dalle notizie riportate dai media...
- Fai di tutto per evitare di arrabbiarti per le piccole avversità quotidiane.



2250 maschi svedesi valutati a 50 anni e successivamente a 60, 70, 77 e 82 anni



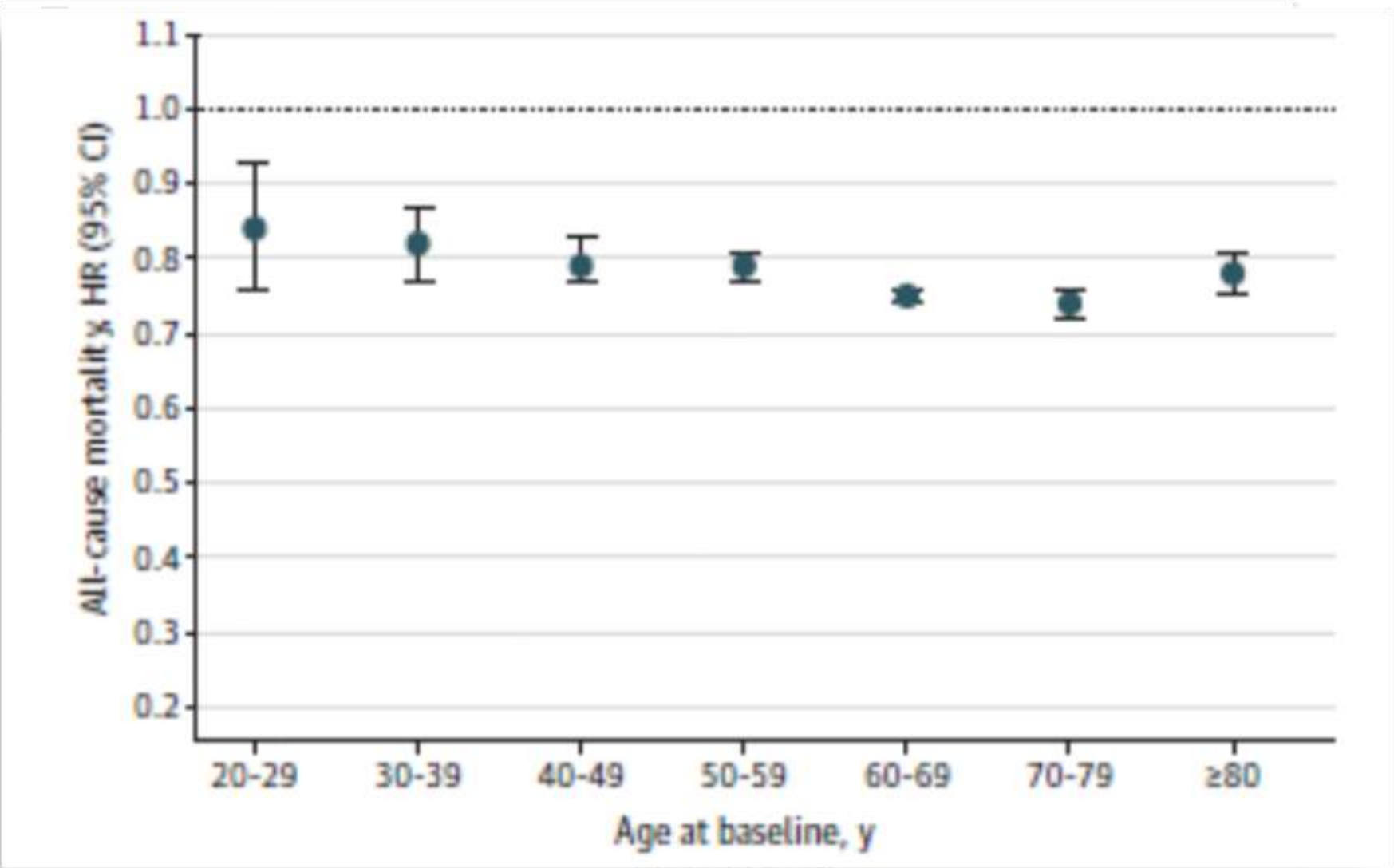
C'è un'associazione dose-dipendente tra livello di attività fisica in età adulta e mortalità da tutte le cause.

L'aumento dell'attività fisica prolunga la sopravvivenza negli uomini adulti e nei giovani anziani, sebbene vi sia probabilmente un periodo di 5-10 anni prima di vedere il beneficio sulla sopravvivenza

L'effetto sulla mortalità dell'aumentata attività fisica equivale a quello osservato con la cessazione del fumo

Physical Activity and All-Cause Mortality by Age in 4 Multinational Megacohorts

Characteristic	Participants, No. (%)
	Total sample (N = 2 011 186)
Sex	
Female	1 105 581 (55.0)
Male	905 605 (45.0)
Age group, y	
20-29	207 726 (10.3)
30-39	345 857 (17.2)
40-49	450 221 (22.4)
50-59	471 148 (23.4)
60-69	408 413 (20.3)
70-79	97 497 (4.9)
≥80	30 324 (1.5)
Educational level	
Low (primary education or lower)	524 467 (26.1)
Middle (secondary education)	949 278 (47.2)
High (university)	537 441 (26.7)
Smoking	
Never	1 233 617 (61.3)
Former	350 164 (17.4)
Current	427 405 (21.3)
Alcohol consumption	
Never or occasional	1 344 119 (66.8)
Infrequent	301 695 (15.0)
Regular	365 372 (18.2)
Physical activity, median (IQR), MET-h/wk	3.5 (0.0-15.8)
Meeting the recommendation ^a	786 682 (39.1)
Body mass index, mean (SD) ^b	25.5 (4.9)
Healthy body weight ^c	1 558 410 (77.5)
Hypertension	386 239 (19.2)
Diabetes	98 706 (4.9)
Cardiovascular disease	112 730 (5.6)
Cancer	90 359 (4.5)
Follow-up duration, median (IQR), y	11.5 (9.3-13.5)
Deaths	177 436 (8.8)



Association of Physical Activity Intensity With Mortality
A National Cohort Study of 403 681 US Adults

Yafeng Wang, MSc; Jing Nie, BSc; Gerson Ferrari, PhD; Juan Pablo Rey-Lopez, PhD; Leandro F. M. Rezende, ScD

Conclusions

This study suggests that a higher proportion of VPA to total physical activity was associated with lower all-cause mortality. Clinicians and public health interventions should encourage achieving the physical activity guidelines to reduce mortality but also advise on the potential benefits associated with VPA to maximize population health.

VPA: Vigorous Physical Activity
MPA: Moderate Physical Activity

Table 4. Adjusted Hazard Ratios for Joint Associations of MPA and VPA With All-Cause Mortality, CVD Mortality, and Cancer Mortality^{a,b}

Mortality	MPA, hazard ratio (95% CI)			
	0 min/wk	1-149 min/wk	150-299 min/wk	≥300 min/wk
All-cause mortality (36 861 deaths)				
VPA, min/wk				
0	1.00 [Reference]	0.86 (0.83-0.89)	0.80 (0.76-0.84)	0.78 (0.73-0.82)
1-74	0.84 (0.77-0.92)	0.71 (0.66-0.76)	0.74 (0.64-0.86)	0.66 (0.58-0.76)
75-149	0.73 (0.67-0.81)	0.66 (0.61-0.72)	0.74 (0.65-0.85)	0.74 (0.64-0.85)
≥150	0.69 (0.64-0.75)	0.64 (0.59-0.69)	0.64 (0.58-0.71)	0.68 (0.62-0.74)
CVD mortality (7634 deaths)				
VPA, min/wk				
0	1.00 [Reference]	0.85 (0.79-0.92)	0.73 (0.64-0.82)	0.71 (0.62-0.81)
1-74	0.78 (0.63-0.97)	0.80 (0.69-0.94)	0.78 (0.56-1.09)	0.70 (0.51-0.97)
75-149	0.85 (0.67-1.07)	0.61 (0.50-0.76)	0.60 (0.41-0.89)	0.64 (0.45-0.91)
≥150	0.71 (0.60-0.84)	0.56 (0.45-0.69)	0.56 (0.45-0.72)	0.56 (0.44-0.68)
Cancer mortality (8902 deaths)				
VPA, min/wk				
0	1.00 [Reference]	0.93 (0.86-1.00)	0.93 (0.84-1.03)	0.88 (0.78-0.98)
1-74	0.83 (0.69-1.00)	0.76 (0.66-0.86)	0.72 (0.55-0.94)	0.67 (0.52-0.86)
75-149	0.83 (0.69-1.00)	0.75 (0.64-0.87)	1.06 (0.83-1.36)	0.93 (0.74-1.16)
≥150	0.83 (0.73-0.96)	0.73 (0.62-0.85)	0.71 (0.58-0.87)	0.82 (0.70-0.97)

MORTALITY

EFFECTS OF WALKING ON MORTALITY AMONG NONSMOKING RETIRED MEN

707 maschi pensionati, 61-81 anni

Periodo di osservazione: 12 anni

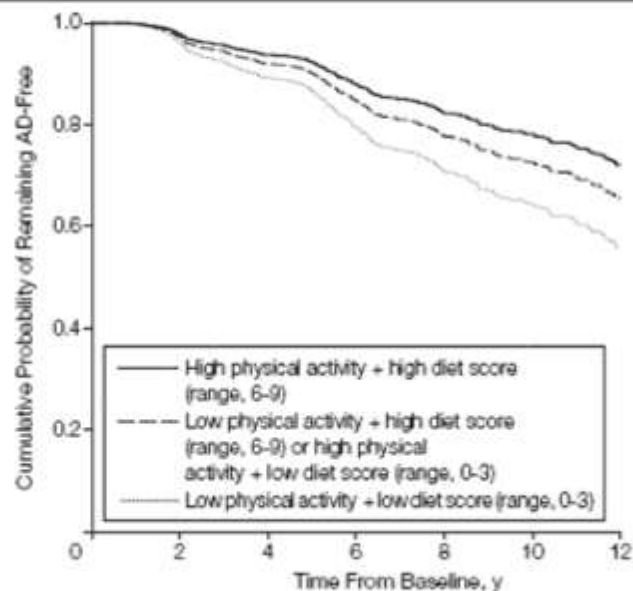
Mortalità per cause	Miglia/giorno	Mortalità (%)
Totale (n.208)	0.0-0.9	40.5
	1.0-2.0	27.4
	2.1-8.0	23.8
Cardiopatía/Ictus (n.52)	0.0-0.9	6.2
	1.0-2.0	5.5
	2.1-8.0	2.3
Cancro (n.68)	0.0-0.9	12.8
	1.0-2.0	9.4
	2.1-8.0	5.6



Physical Activity, Diet, and Risk of Alzheimer Disease

Rischio di **demenza di Alzheimer** in relazione a **dieta mediterranea** e **attività fisica** in 587 persone, età media 77 anni, follow-up 16 anni

Figure 2. Alzheimer Disease (AD) Incidence by High or Low Physical Activity Levels and Mediterranean-Type Diet Adherence Scores



Neuroprotective mechanisms of exercise and the importance of fitness for healthy brain ageing

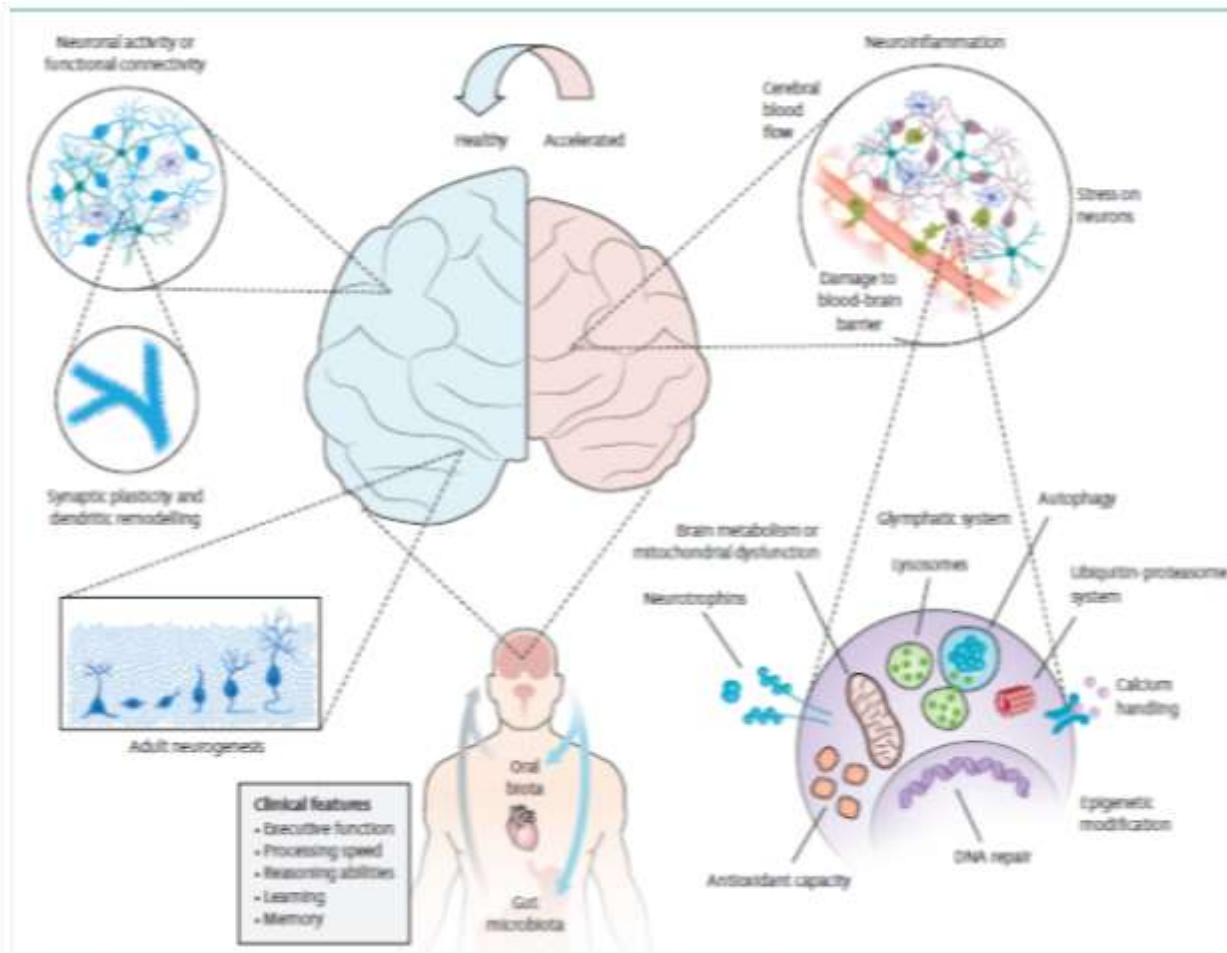
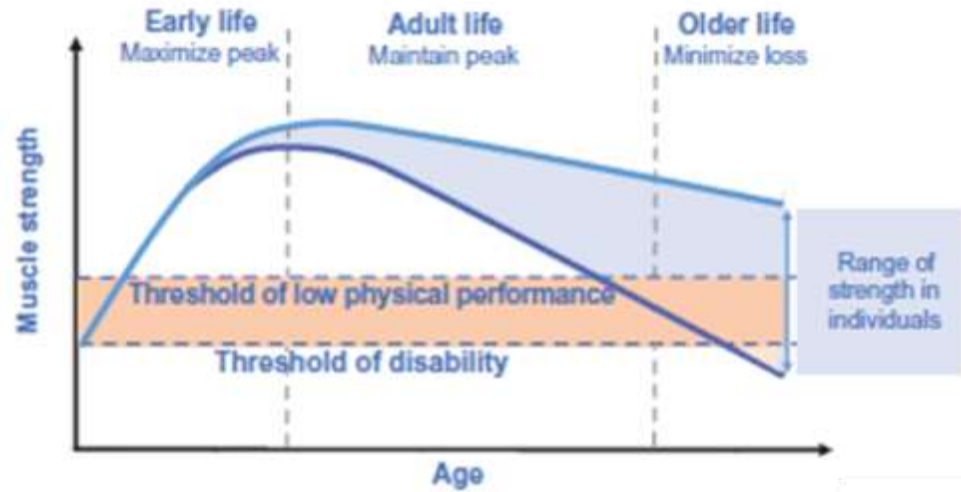


Figure 1: Clinical, tissue, and molecular differences between healthy ageing and accelerated ageing

FORZA MUSCOLARE NEL CORSO DELLA VITA



FORMA MUSCOLARE IN MASCHI E FEMMINE

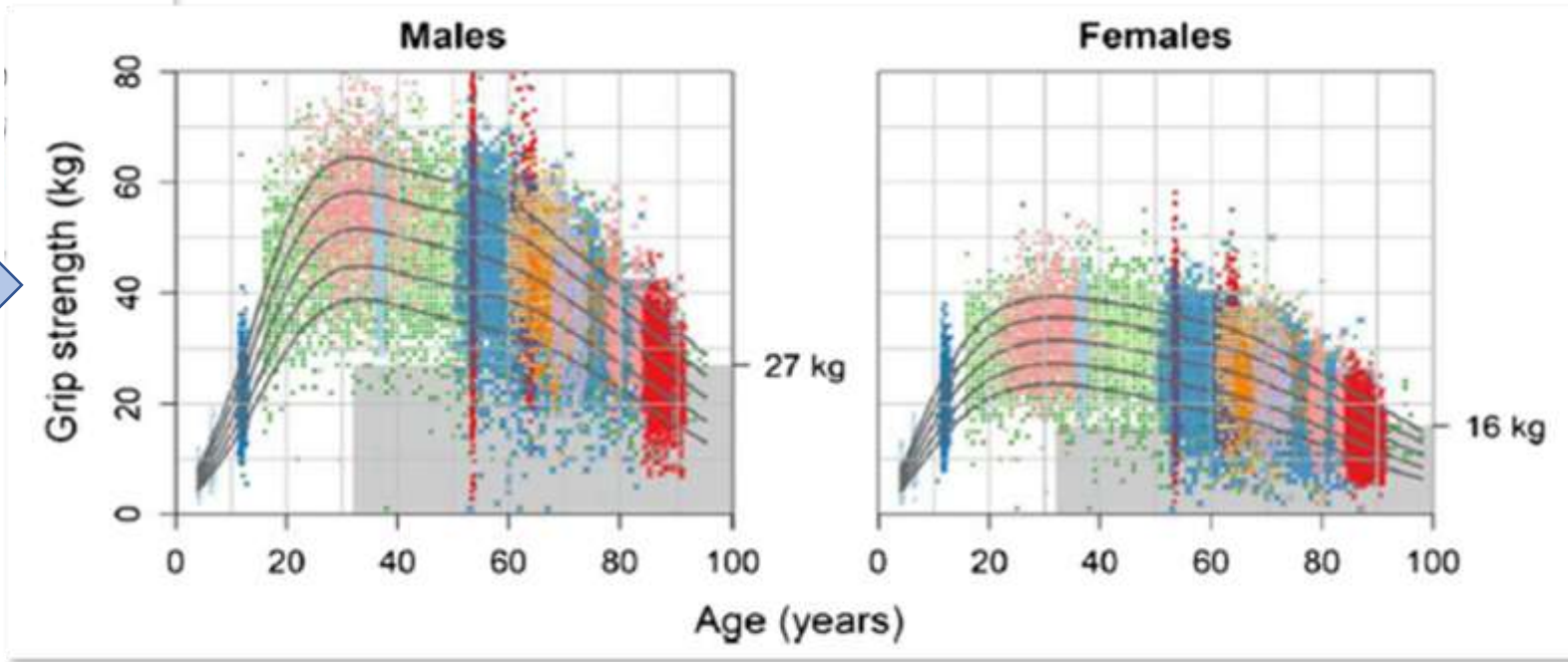


Figure 2. Normative data for grip strength across the life course in men and women in the UK (Dodds RM, *et al.* PLoS One. 2014;9:e113637). Centiles shown are 10th, 25th, 50th, 75th and 90th. Cut-off points based on T -score of ≤ -2.5 are shown for males and females (≤ 27 kg and 16 kg, respectively). Color-coding represents different birth cohorts used for the study (Figure adapted with permission from R Dodds and PLoS One).

Sarcopenia: revised European consensus on definition and diagnosis

Age and Ageing 2018; **0**: 1–16
doi: 10.1093/ageing/afy169

ALFONSO J. CRUZ-JENTOFT¹, GÜLISTAN BAHAT², JÜRGEN BAUER³, YVES BOIRIE⁴, OLIVIER BRUYÈRE⁵, TOMMY CEDERHOLM⁶, CYRUS COOPER⁷, FRANCESCO LANDI⁸, YVES ROLLAND⁹, AVAN AIHIE SAYER¹⁰, STÉPHANE M. SCHNEIDER¹¹, CORNEL C. SIEBER¹², EVA TOPINKOVA¹³, MAURITS VANDEWOUDE¹⁴, MARJOLEIN VISSER¹⁵, MAURO ZAMBONI¹⁶, WRITING GROUP FOR THE EUROPEAN WORKING GROUP ON SARCOPENIA IN OLDER PEOPLE 2 (EWGSOP2), AND THE EXTENDED GROUP FOR EWGSOP2

Table 1. 2018 operational definition of sarcopenia

Probable sarcopenia is identified by Criterion 1.

Diagnosis is confirmed by additional documentation of Criterion 2.

If Criteria 1, 2 and 3 are all met, sarcopenia is considered severe.

(1) Low muscle strength

(2) Low muscle quantity or quality

(3) Low physical performance

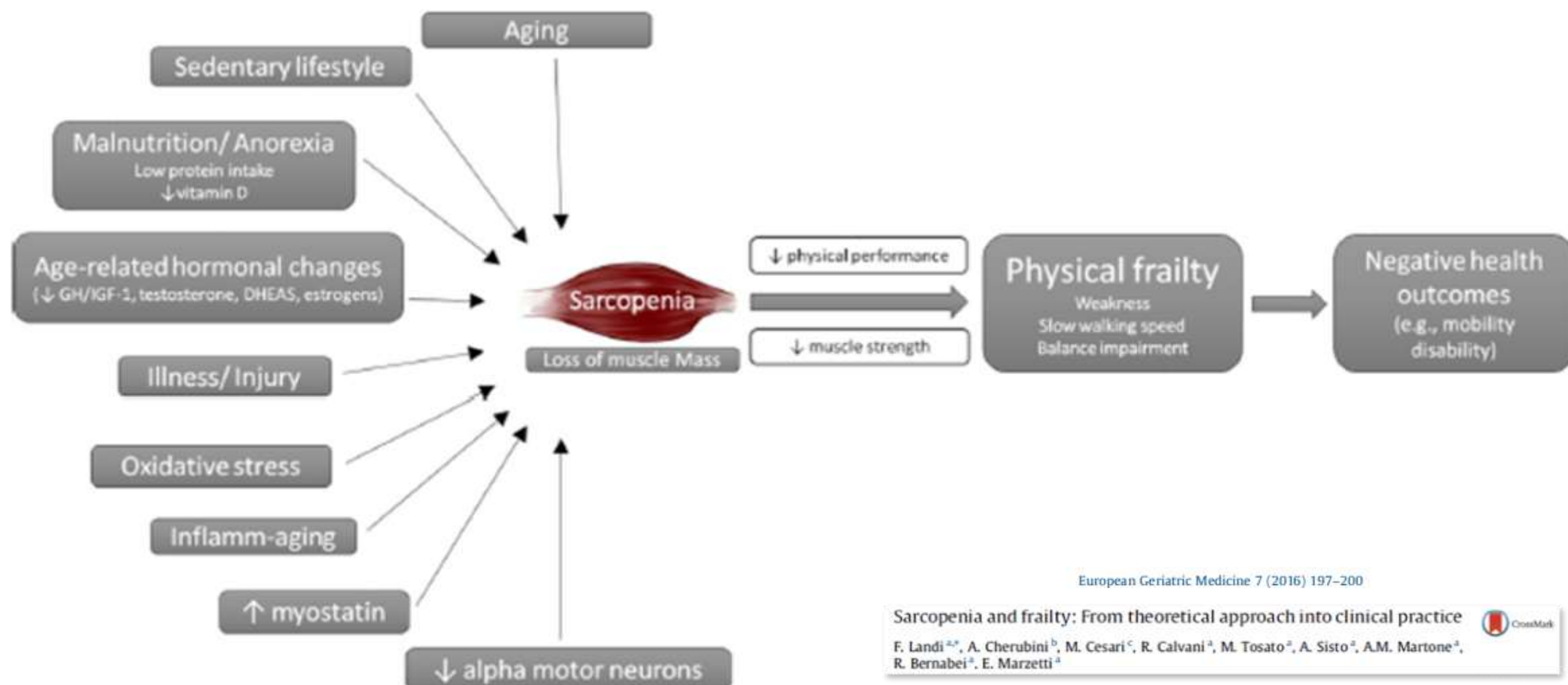


Sarcopenia

Alfonso J Cruz-Jentoft, Avon A Sayer

Definition

Sarcopenia has been defined as a progressive and generalised skeletal muscle disorder that involves the accelerated loss of muscle mass and function. Sarcopenia is associated with increased adverse outcomes including falls, functional decline, frailty, and mortality.¹⁵ When



European Geriatric Medicine 7 (2016) 197–200

Sarcopenia and frailty: From theoretical approach into clinical practice

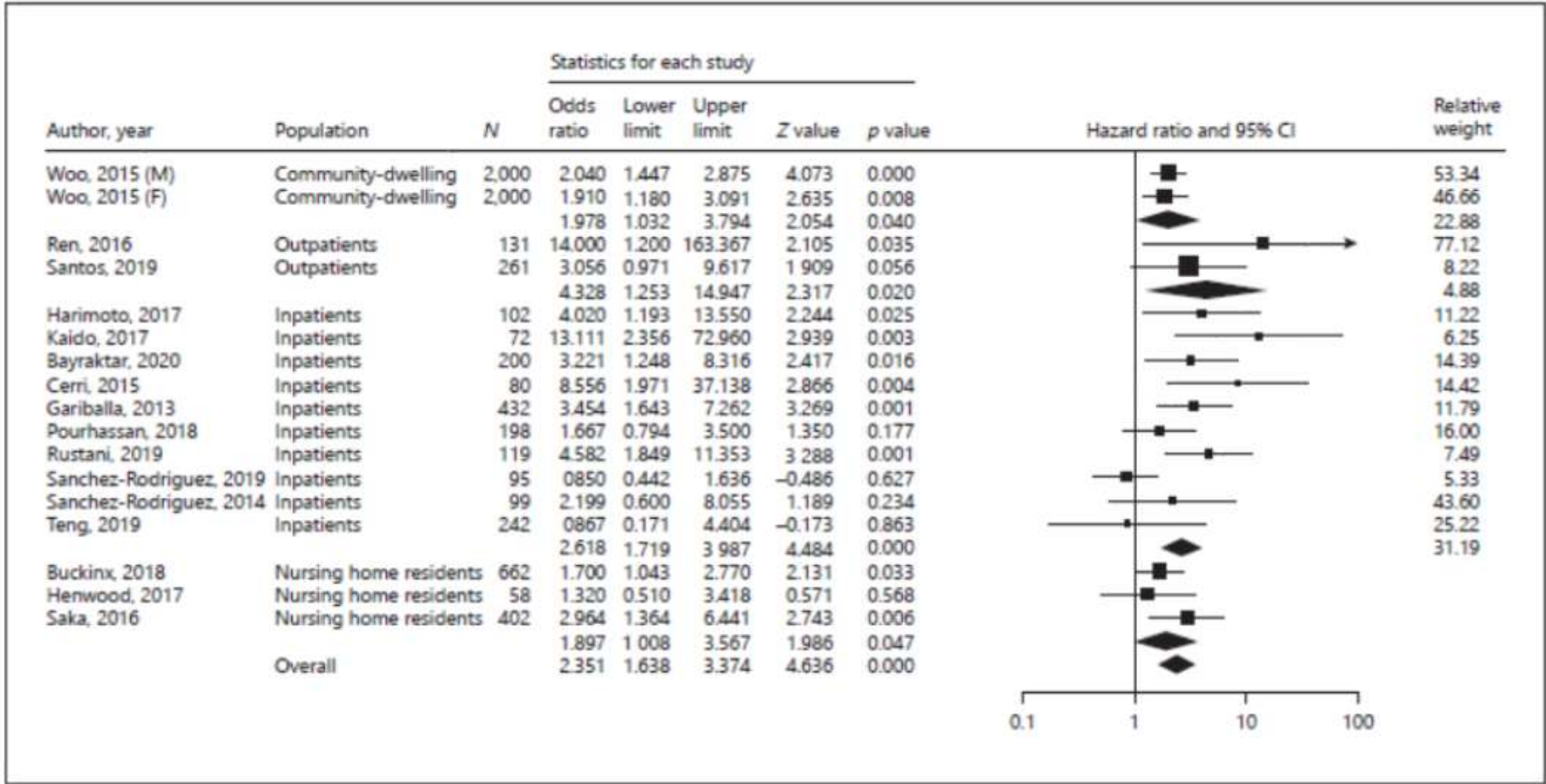
F. Landi^{a,*}, A. Cherubini^b, M. Cesari^c, R. Calvani^a, M. Tosato^a, A. Sisto^a, A.M. Martone^a, R. Bernabei^a, E. Marzetti^a



Sarcopenia Is Associated with Mortality in Adults: A Systematic Review and Meta-Analysis

Gerontology 2022;68:361–376

CLINICAL IMPLICATIONS OF SARCOPENIA



The Journals of Gerontology, Series A: Biological Sciences and Medical Sciences, 2025, 80(1), glae266
https://doi.org/10.1093/gerona/glae266

Association of Low Muscle Strength With Incident Pneumonia in Older Patients With Heart Failure

FRAGILE-HF study, 1296 HF patients aged 65 years or older (mean age 80.2)

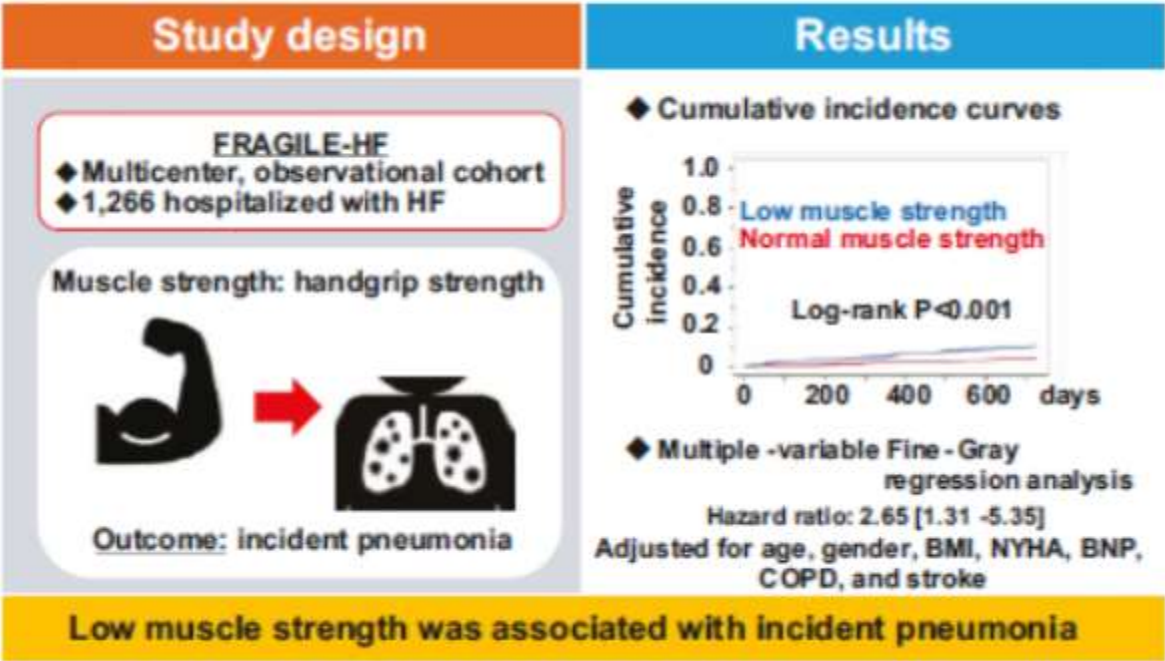


Table 3. Multiple-Variable Fine–Gray Regression Model With Patients Who Died Without Pneumonia Treated as a Competing Risk

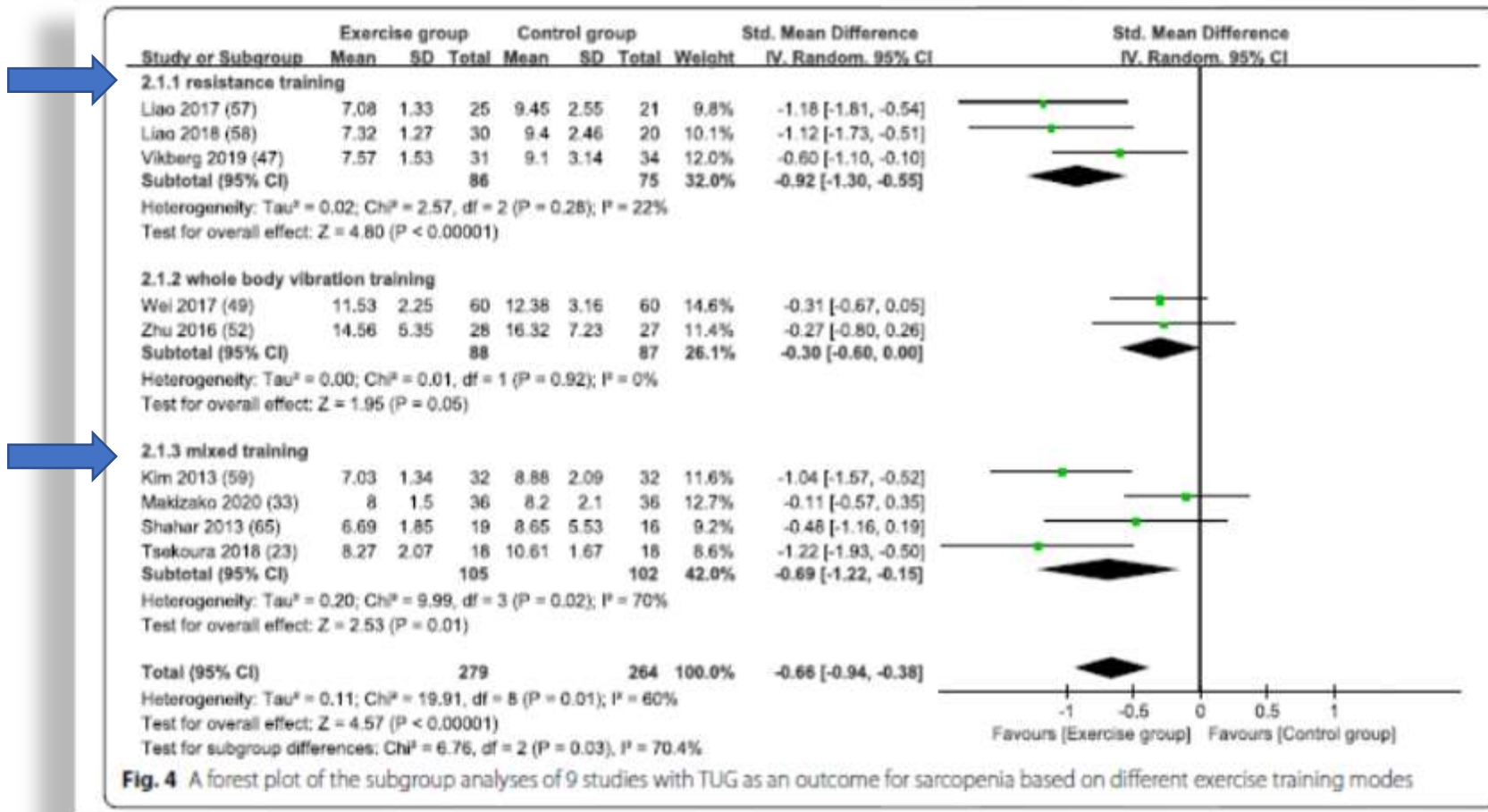
Variables	HR (95% CI)	p Value
Age (years)	1.00 (0.97–1.03)	.840
Male gender	2.16 (1.31–3.57)	.003
BMI (kg/m ²)	0.96 (0.89–1.03)	.200
NYHA class III/IV	1.56 (0.89–2.75)	.120
Log BNP	1.33 (0.83–2.12)	.240
COPD	1.22 (0.68–2.19)	.500
Cerebral infarction/TIA	1.36 (0.78–2.37)	.280
Low muscle strength	2.65 (1.31–5.35)	.007

Timed Up and Go

RT: resistance training

WBVT: whole body vibration training

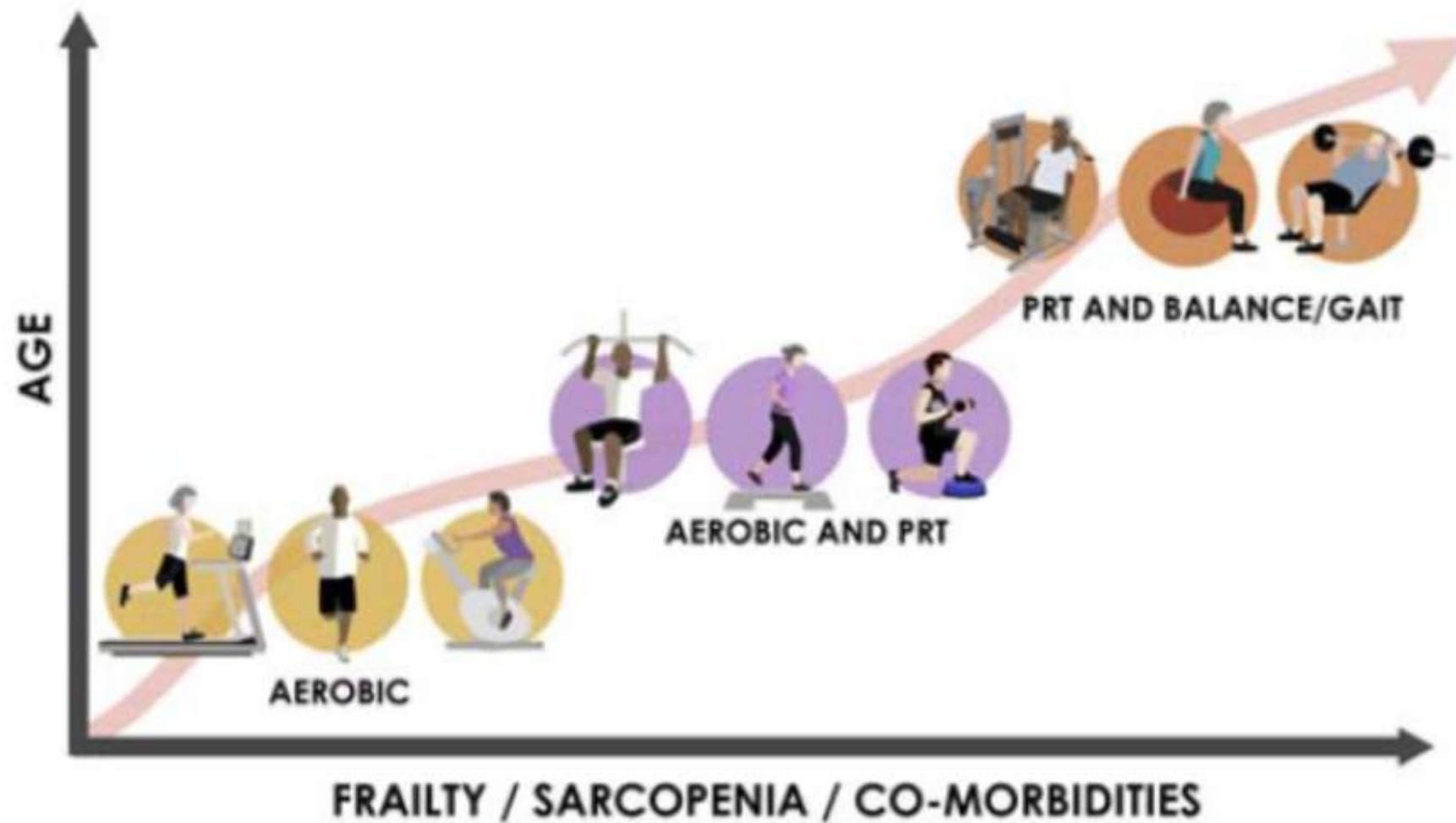
MT: mixed (balance and aerobic) training



Fabbisogno proteico:
Adulti sani 0.8 g/Kg/die
Adulti pre-sarcopenici: 1-1.2 g/Kg/die

Global consensus on optimal exercise recommendations for enhancing healthy longevity in older adults (ICFSR)

Optimal Exercise Prescription Changes over Time

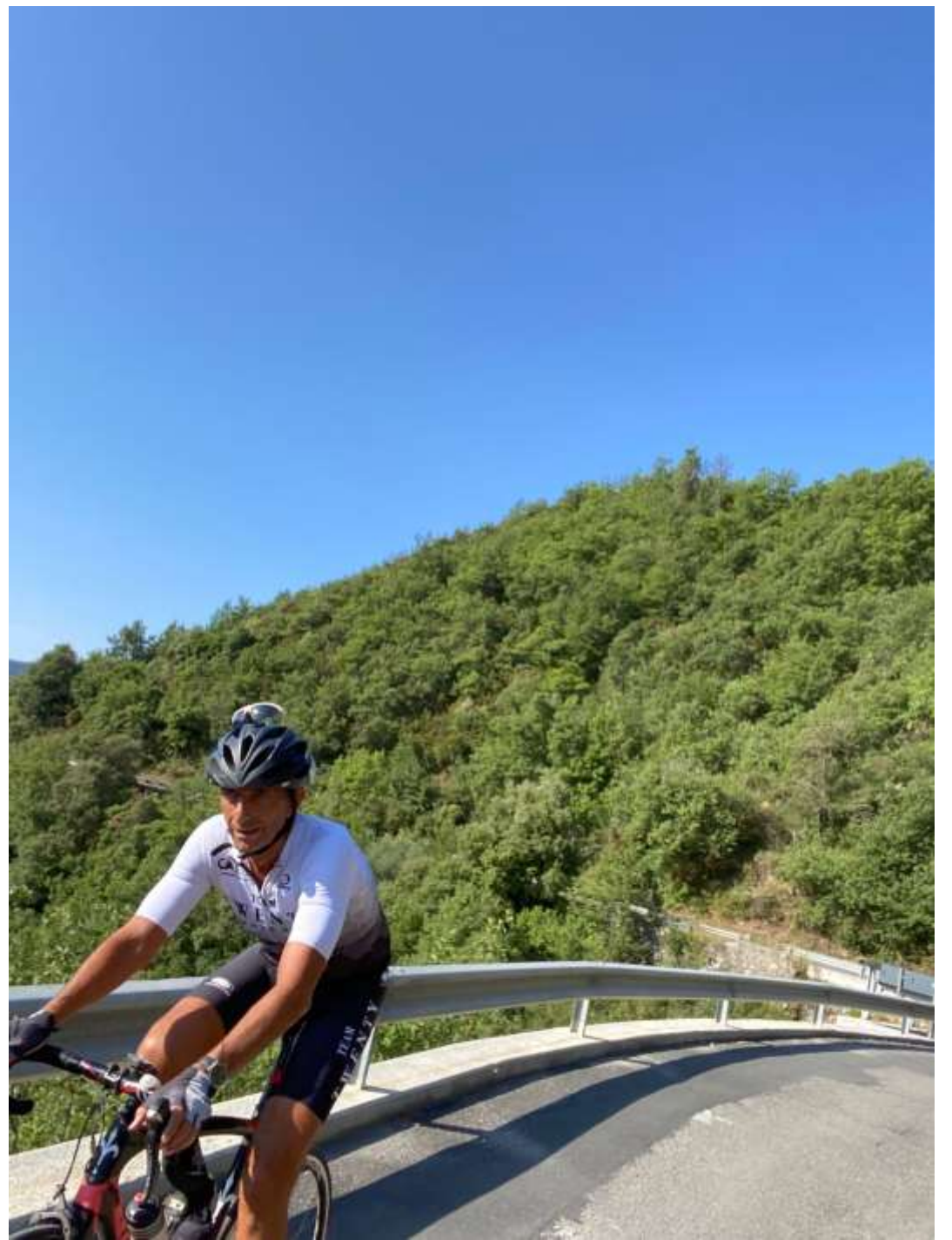
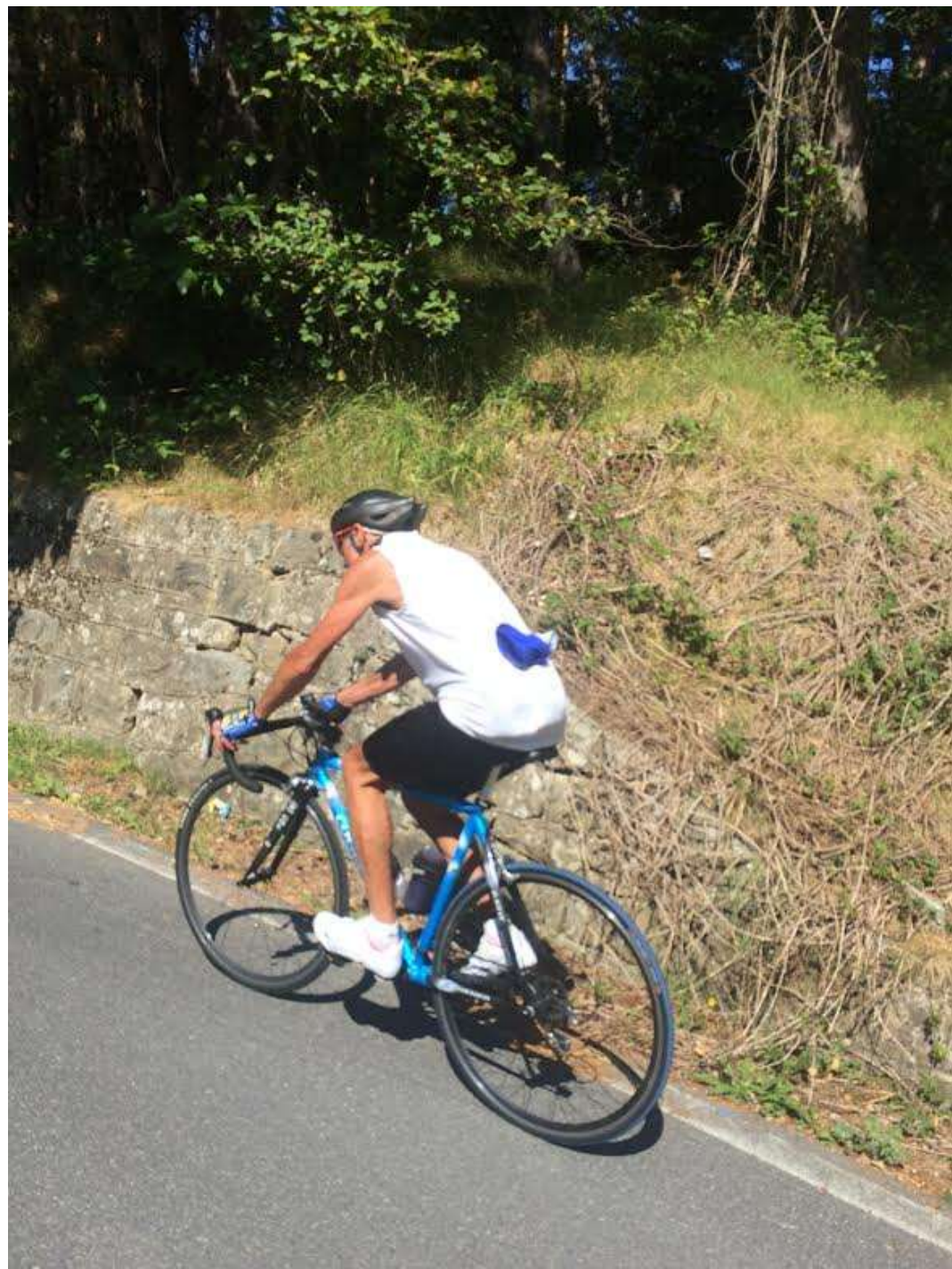


Brief Review

(Hypertension. 2018;71:389-402.

Strategies for Achieving Healthy Vascular Aging

Healthy Lifestyle Strategy	Effects	Evidence
 Aerobic exercise	↓ ↔ arterial stiffness ↔ blood pressure	
  Calorie restriction/ weight loss	↓ arterial stiffness ↓ blood pressure	
 Dietary sodium restriction	↓ arterial stiffness ↓ blood pressure	
 Flavonoids	↓ arterial stiffness ↔ blood pressure	
 Healthy dietary patterns (DASH, Mediterranean)	↓ (?) arterial stiffness ↓ blood pressure	



**Pastiglie
e Interventi**

**Cambio
stile di vita**



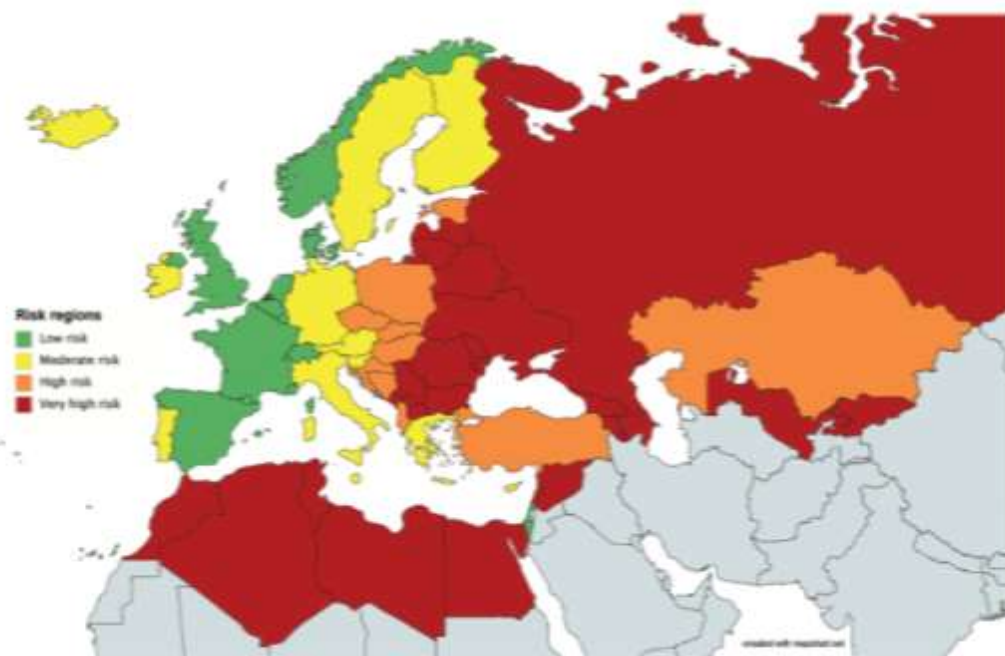
"Troppo sedentari e poco sociali"

Identikit degli anziani piemontesi

Sara Strippoli (La Repubblica, 12/2/2020)

Nonostante gli appelli, i consigli dei medici, i convegni frequentati dagli esperti, l'identikit degli anziani piemontesi è quello di una generazione sedentaria, poco impegnata in una attività sociale e ha problemi ad accedere ai servizi sanitari.... La fotografia, in un confronto con altre 17 regioni italiane offerto dall'Osservatorio permanente "Passi d'Argento", dice che il **37% dei piemontesi sono sedentari** e il 64% è escluso dalla vita sociale.

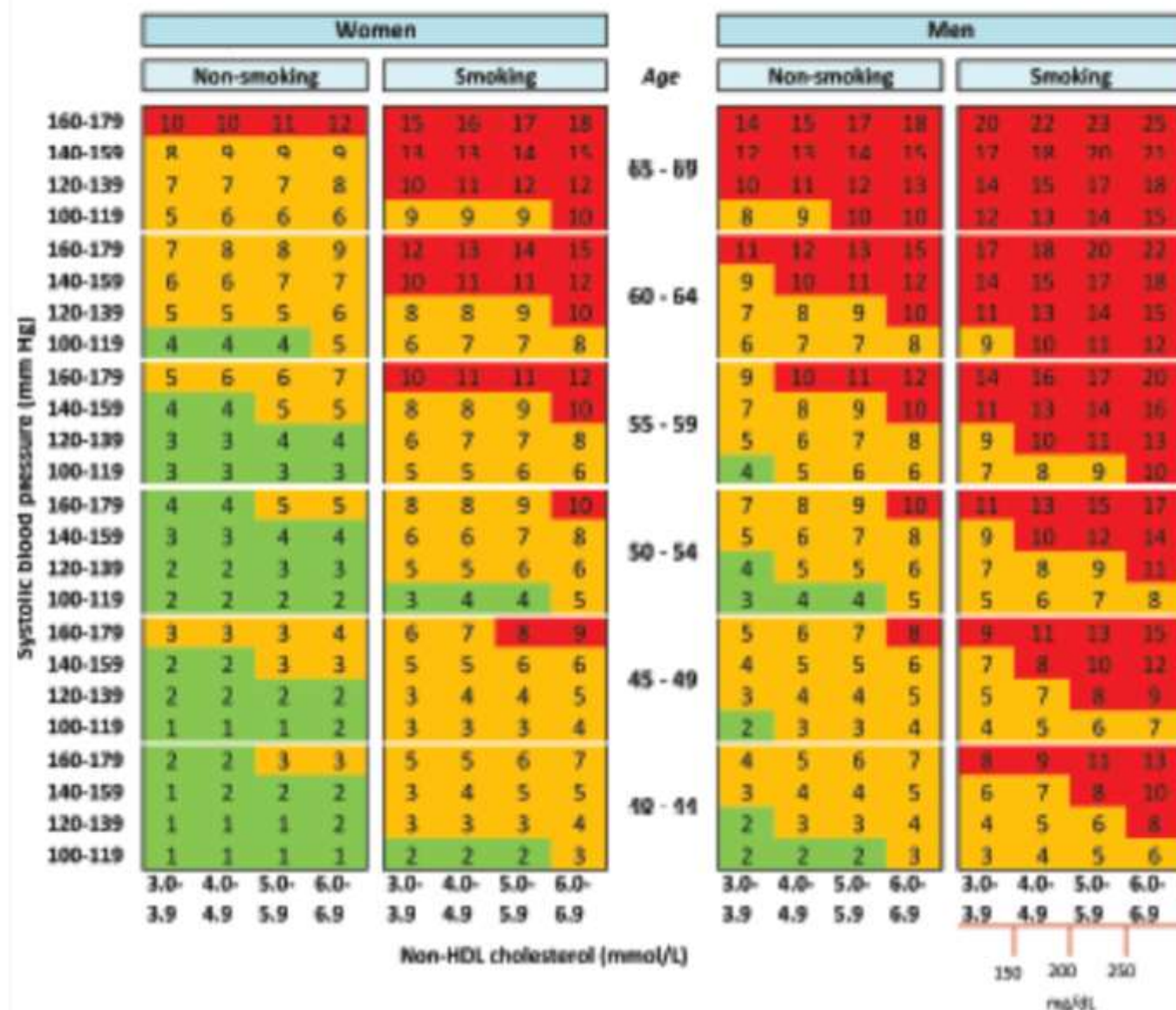
2021 ESC Guidelines on cardiovascular disease prevention in clinical practice



B

SCORE2

10-year risk of (fatal and non-fatal)
CV events in populations at
moderate CVD risk



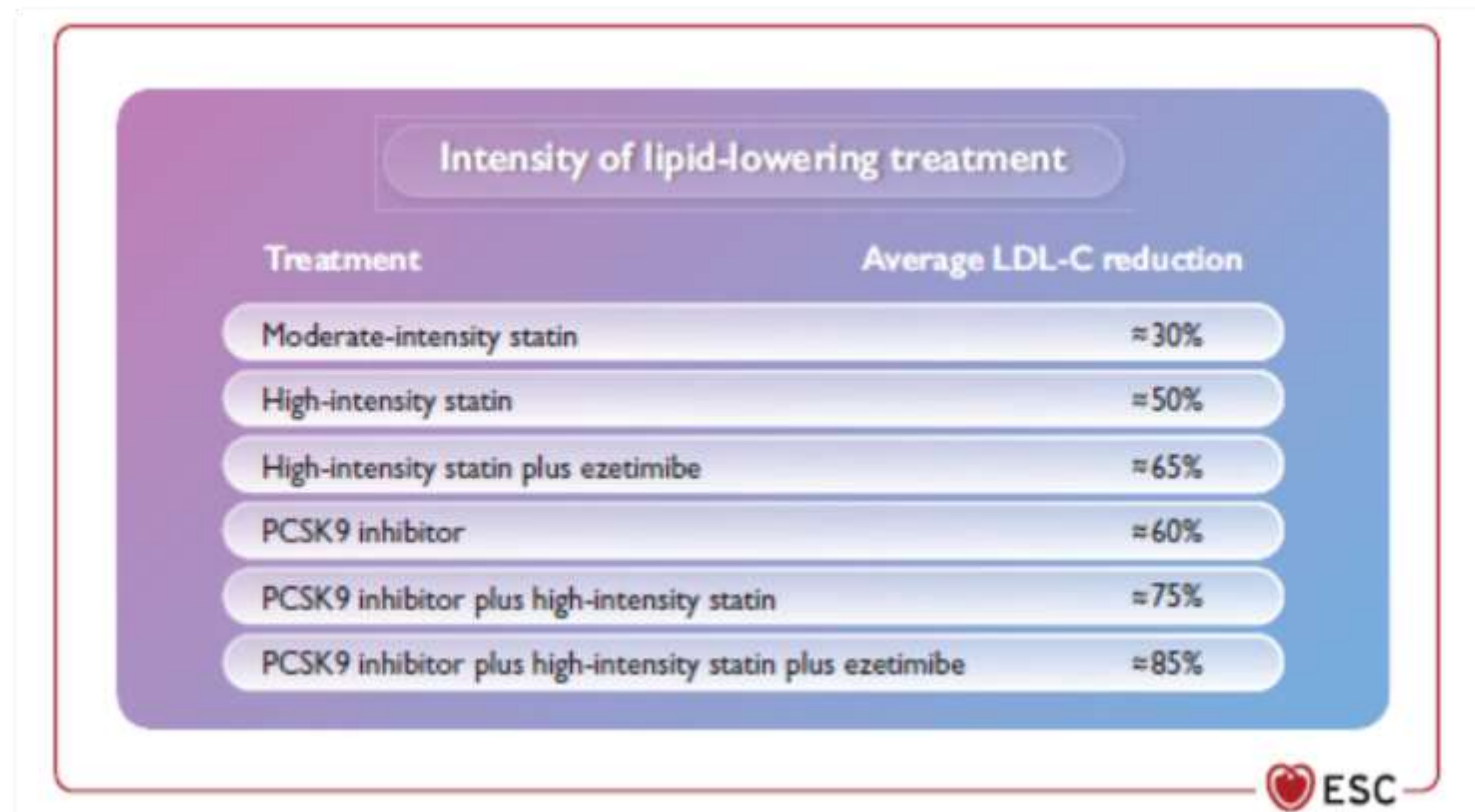
2021 ESC Guidelines on cardiovascular disease prevention in clinical practice

Patient category	Prevention goals (STEP 1)	Intensified/additional prevention goals ^a (STEP 2)
Apparently healthy persons	For BP and lipids: initiation of drug treatment based on CVD risk assessment (Table 5) or SBP >160 mmHg	
<50 years	Stop smoking and lifestyle optimization SBP <140 down to 130 mmHg if tolerated ^b LDL-C <2.6 mmol/L (100 mg/dL)	SBP <130 mmHg if tolerated ^b LDL-C <1.8 mmol/L (70 mg/dL) and ≥50% reduction in high-risk patients LDL-C <1.4 mmol/L (55 mg/dL) and ≥50% reduction in very-high-risk patients
50–69 years	Stop smoking and lifestyle optimization SBP <140 down to 130 mmHg if tolerated ^b LDL-C <2.6 mmol/L (100 mg/dL)	SBP <130 mmHg if tolerated ^b LDL-C <1.8 mmol/L (70 mg/dL) and ≥50% reduction in high-risk patients LDL-C <1.4 mmol/L (55 mg/dL) and ≥50% reduction in very-high-risk patients
≥70 years	Stop smoking and lifestyle optimization SBP <140 mmHg if tolerated ^b LDL-C <2.6 mmol/L (100 mg/dL)	For specific risk factor management in patients ≥70 years old, please see relevant sections in section 4 .
Patients with CKD	Stop smoking and lifestyle optimization SBP <140 down to 130 mmHg if tolerated ^b LDL-C <2.6 mmol/L (100 mg/dL) and ≥50% LDL-C reduction Otherwise according to ASCVD and DM history	LDL-C <1.8 mmol/L (70 mg/dL) in high-risk patients and <1.4 mmol/L (55 mg/dL) in very-high risk patients (see Table 4)

Table 18 Recommended office blood pressure target ranges. The first step in all groups is a reduction to systolic blood pressure <140 mmHg. The subsequent optimal goals are listed below.

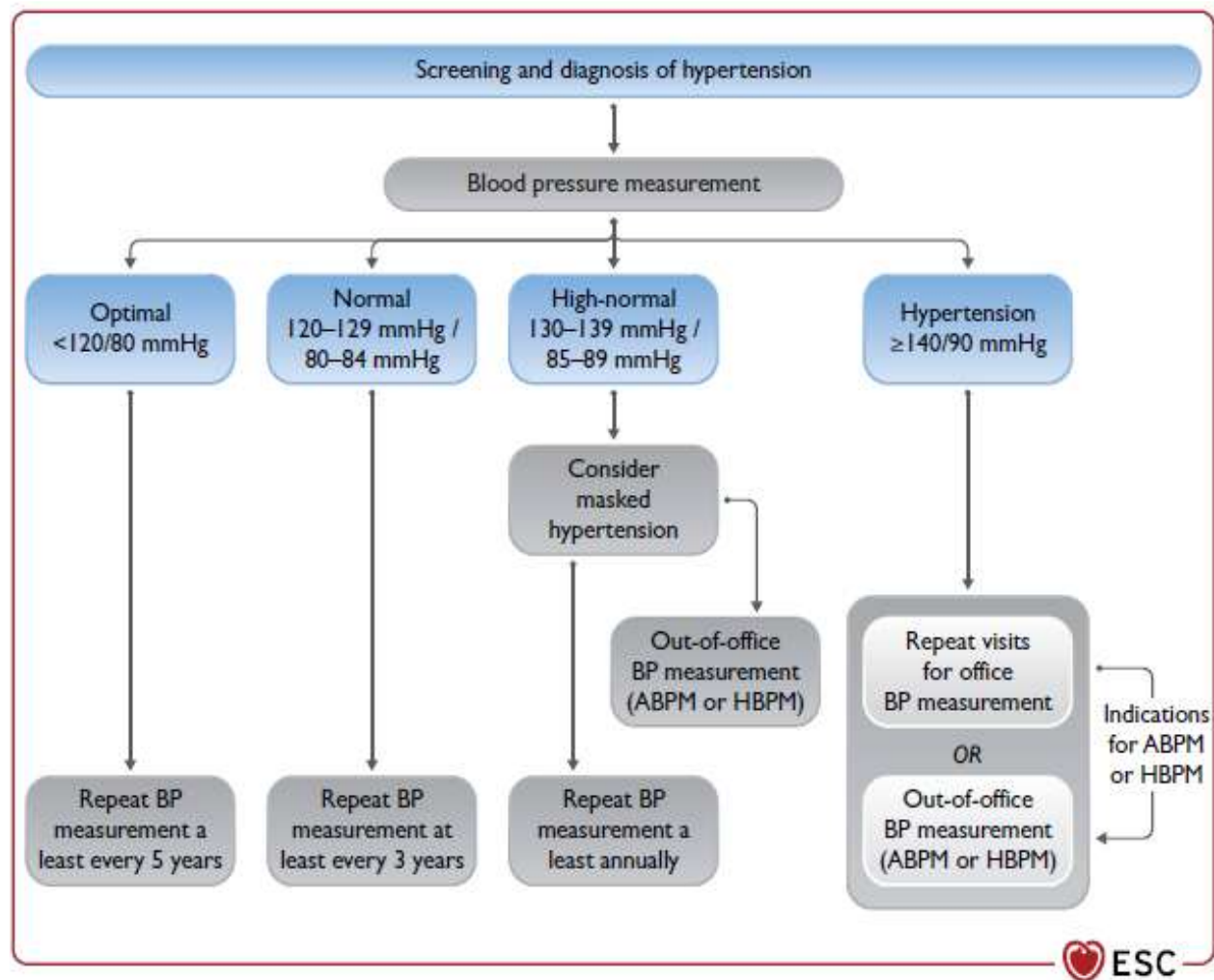
Age group	Office SBP treatment target ranges (mmHg)				
	Hypertension	+ DM	+ CKD	+ CAD	+ Stroke/TIA
18 – 69 years	120–130	120–130	<140–130	120–130	120–130
	<i>Lower SBP acceptable if tolerated</i>				
≥70 years	<140 mmHg, down to 130 mmHg if tolerated				
	<i>Lower SBP acceptable if tolerated</i>				
DBP treatment target (mmHg)	<80 for all treated patients				

Recommendations	Class ^a	Level ^b
It is recommended that a high-intensity statin is prescribed up to the highest tolerated dose to reach the LDL-C goals set for the specific risk group. ^{21,520,521}	I	A
An ultimate ^c LDL-C goal of <1.4 mmol/L (55 mg/dL) and LDL-C reduction of ≥50% from baseline should be considered in apparently healthy persons <70 years at very high risk. ^{21,22,522}	IIa	C
An ultimate ^c LDL-C goal of <1.8 mmol/L (70 mg/dL) and LDL-C reduction of ≥50% from baseline should be considered in apparently healthy persons <70 years at high risk. ^{21,22,522}	IIa	C
In patients with established ASCVD, lipid-lowering treatment with an ultimate ^c LDL-C goal of <1.4 mmol/L (55 mg/dL) and a ≥50% reduction in LDL-C vs. baseline is recommended. ^{21,508,515–517,522}	I	A
If the goals are not achieved with the maximum tolerated dose of a statin, combination with ezetimibe is recommended. ⁵¹⁵	I	B
For primary prevention patients at very high risk, but without FH, if the LDL-C goal is not achieved on a maximum tolerated dose of a statin and ezetimibe, combination therapy including a PCSK9 inhibitor may be considered.	IIb	C



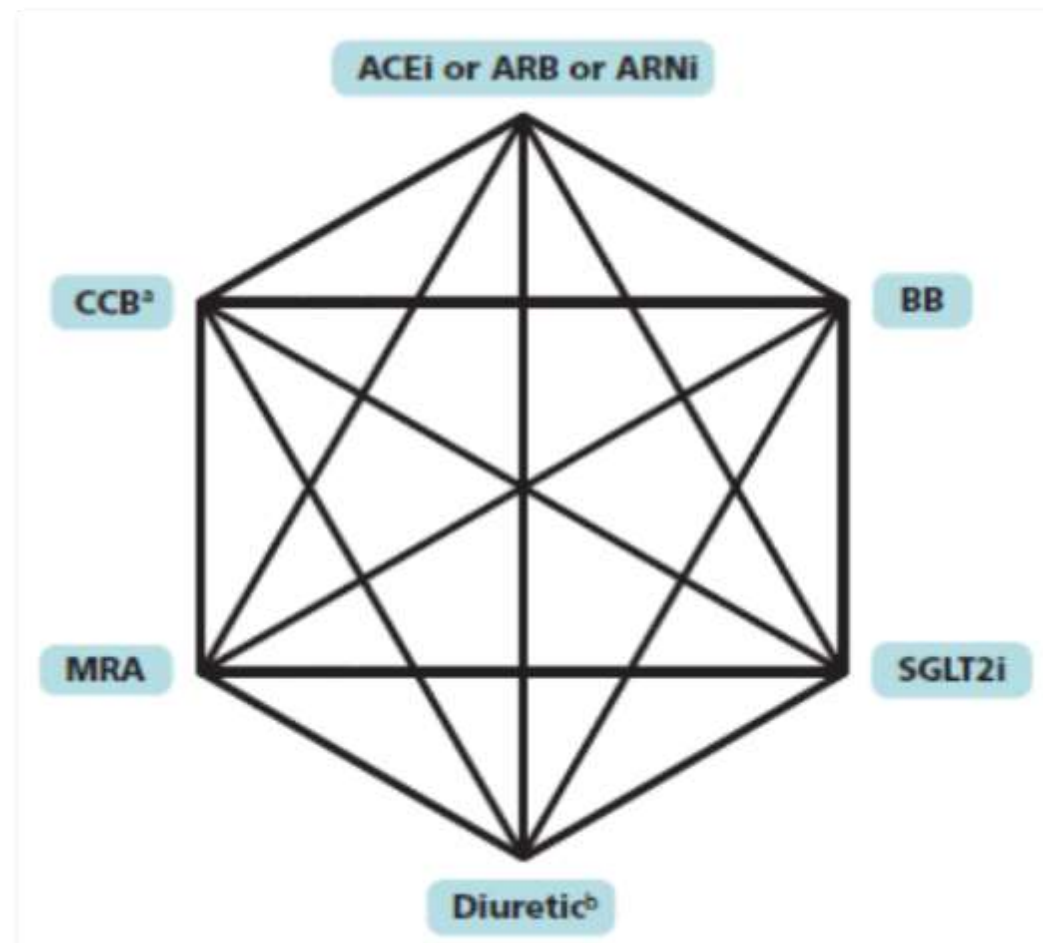
Acido bempedoico
Inclisiran

2021 ESC Guidelines on cardiovascular disease prevention in clinical practice



2023 ESH Guidelines for the management of arterial hypertension

The Task Force for the management of arterial hypertension of the European Society of Hypertension



Risk of Severe Hypoglycemia With Newer Second-line Glucose-lowering Medications in Older Adults With Type 2 Diabetes Stratified by Known Indicators of Hypoglycemia Risk

the European Association for the Study of Diabetes (EASD)

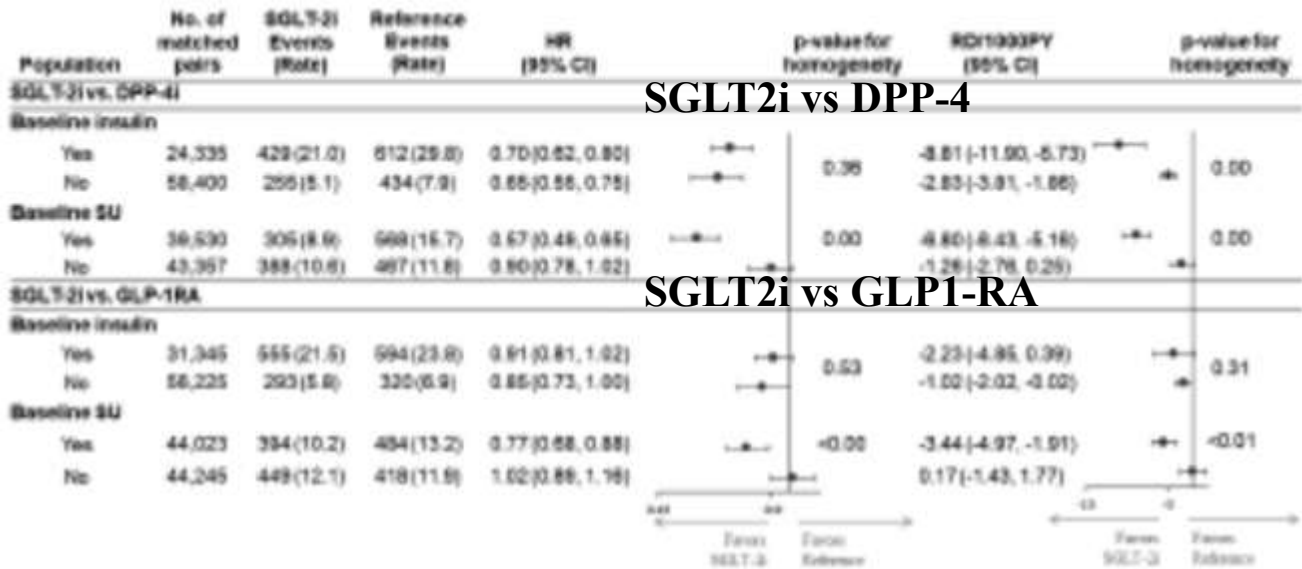
Metformina, sulfaniluree
Glitazoni, Acarbose

GLP1 agonisti (dulaglutide, exenatide, lixisenatide, semaglutide, tirzepatide)

DPP-4 Is (sitagliptin, vildagliptin, saxagliptin, alogliptin, linagliptin)

SGLT-2 Is (canagliflozin, dapagliflozin, empagliflozin, bexagliflozin)

Insuline Lente e Rapide

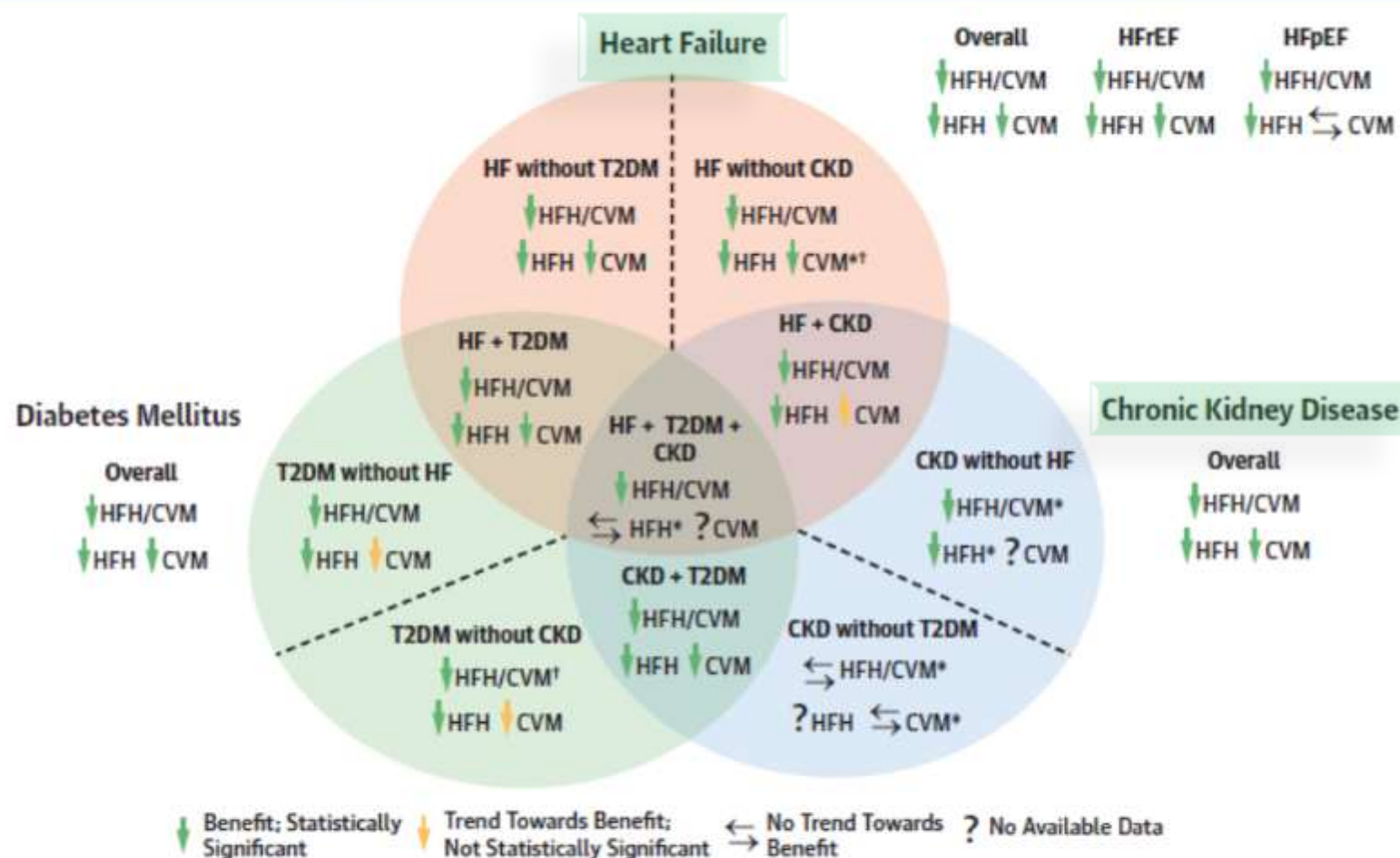


cite as: J Gerontol A Biol Sci Med Sci, 2023, Vol. 78, No. 12, 2426–2434

Figure 1. Association of SGLT2i versus DPP-4i or GLP-1RA with risk of hypoglycemia by baseline use of insulin or SU. DPP4i = dipeptidyl peptidase-4 inhibitors; GLP-1RA = glucagon-like peptide-1 receptor agonist; HR = hazard ratios; PS = propensity-score; RD = rate difference; SGLT2i = sodium-glucose cotransporter 2 inhibitors; SU = sulfonylurea.

Effect of SGLT2 Inhibitors on Cardiovascular Outcomes Across Various Patient Populations

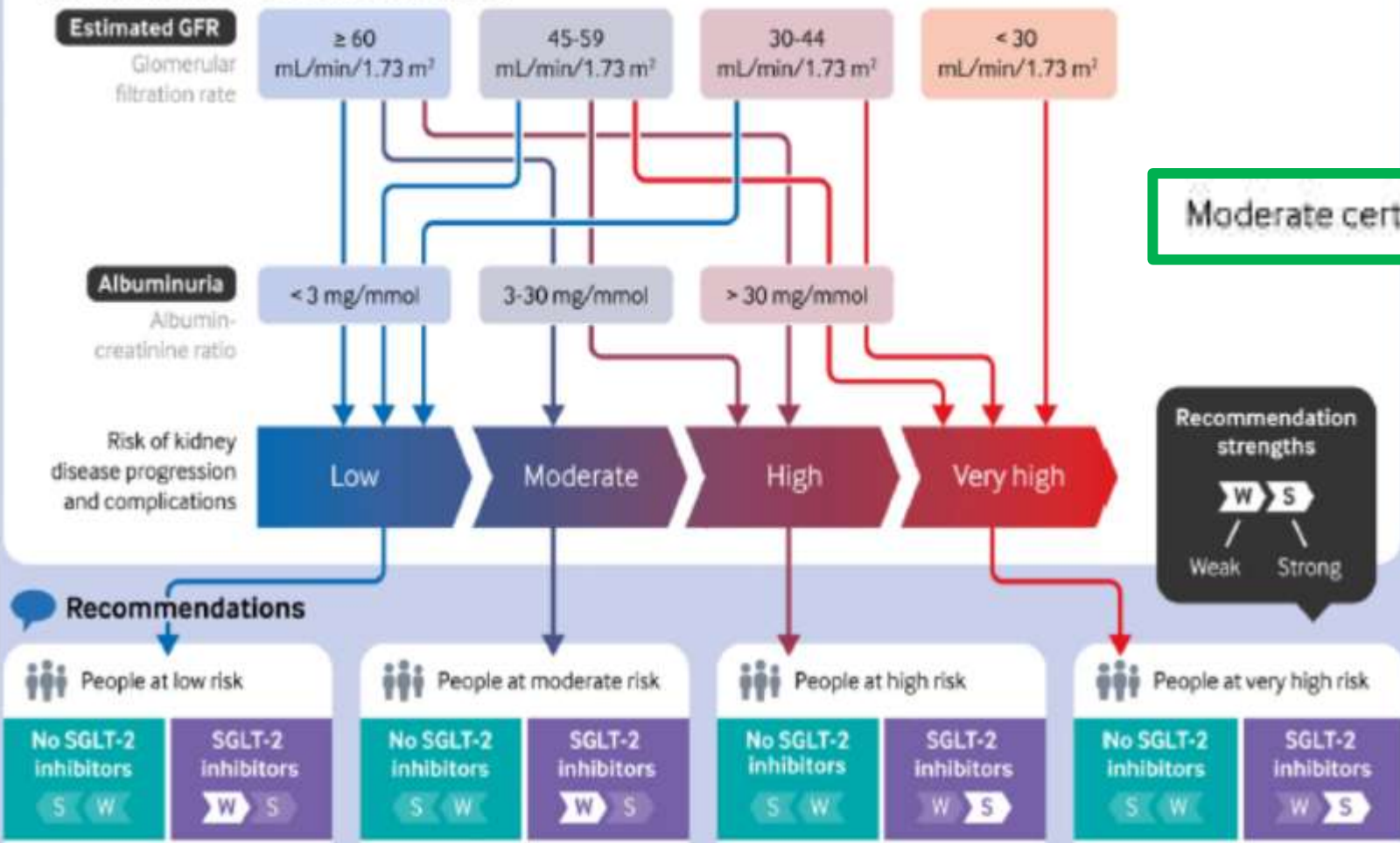
CENTRAL ILLUSTRATION Effect of Sodium-Glucose Cotransporter-2 Inhibitors on Cardiovascular Outcomes Across Different Patient Populations



Usman MS, et al. J Am Coll Cardiol. 2023;81(25):2377-2387.

Sodium-glucose cotransporter-2 (SGLT2) inhibitors reduce the risk of first heart failure hospitalization (HFH)/cardiovascular mortality (CVM) as well as first HFH in heart failure (HF), type 2 diabetes mellitus (T2DM), and chronic kidney disease (CKD) populations. The effect is consistent when subgroups with different combinations of these diseases are assessed. SGLT2 inhibitors appear to reduce CV death in most subgroups with sufficient data available. *Data reported by ≥ 2 studies. †Borderline significant ($P = 0.05$).

Risk stratification for recommendations:



Moderate certainty of no important increase in the risk of harms

We suggest administering SGLT2-Is (weak recommendation in favour)

We recommend administering SGLT2-Is (strong recommendation in favour)



Midlife Risk Factors and Healthy Survival in Men

JAMA. 2006;296:2343-2350

Studio prospettico di coorte su uomini adulti (54 anni al basale) seguiti per 40 anni

Table 3. Stepwise Logistic Regression Model of Risk of Death (Nonsurvival) or Unhealthy Survival (Usual Survival) at Age 85 Years*

Risk Factors	Nonsurvival† vs Survival (n = 3198 vs 2327)		Usual Survival‡ vs Exceptional Survival§ (n = 1720 vs 607)	
	OR (95% CI)	P Value	OR (95% CI)	P Value
Situazione a 45 anni				
Situazione a 85 anni				
Biological				
Overweight at midlife (BMI ≥25)	1.13 (1.00-1.28)	.044	1.49 (1.19-1.86)	<.001
High glucose (≥200 mg/dL)	1.64 (1.41-1.91)	<.001	1.65 (1.21-2.25)	.002
High triglycerides (≥150 mg/dL)	1.11 (0.99-1.25)	.08	1.26 (1.03-1.54)	.03
Hypertension (≥140/90 mm Hg or medication use)	1.45 (1.29-1.63)	<.001	1.61 (1.29-2.00)	<.001
Low grip strength (<39 kg)	1.25 (1.11-1.40)	<.001	1.24 (1.01-1.52)	.04
Lifestyle				
Ever smoker	1.94 (1.72-2.18)	<.001	1.23 (1.01-1.50)	.04
High alcohol consumption (≥3 drinks/d)	1.58 (1.34-1.88)	<.001	1.61 (1.11-2.34)	.01
Sociodemographic				
Low education (<12 y)			1.56 (1.28-1.91)	<.001
Unmarried	1.59 (1.27-2.00)	<.001		

2021 ESC Guidelines on cardiovascular disease prevention in clinical practice

Recommendations	Class ^a	Level ^b
Aspirin 75 - 100 mg daily is recommended for secondary prevention of CVD. ⁶¹⁹	I	A
Antiplatelet therapy is not recommended in individuals with low/moderate CV risk due to the increased risk of major bleeding. ^{624,626-630}	III	A

European Heart Journal (2019) 00, 1–69

Recommendations for the use of antiplatelet therapy in primary prevention in patients with diabetes

Recommendations	Class ^a	Level ^b
In patients with DM at high/very high risk, ^c aspirin (75 - 100 mg/day) may be considered in primary prevention in the absence of clear contraindications. ^{d 231}	IIb	A
In patients with DM at moderate CV risk, ^c aspirin for primary prevention is not recommended.	III	B

Journal of Hypertension 2023, 41:1874–2071

Recommendations and statements	CoR	LoE
Low-dose aspirin is not recommended for primary prevention in patients with hypertension.	III	A
Antiplatelet therapy is recommended for secondary prevention in hypertensive patients.	I	A
Use of a poly pill containing low-dose aspirin can be considered in hypertensive patients for secondary prevention.	II	A

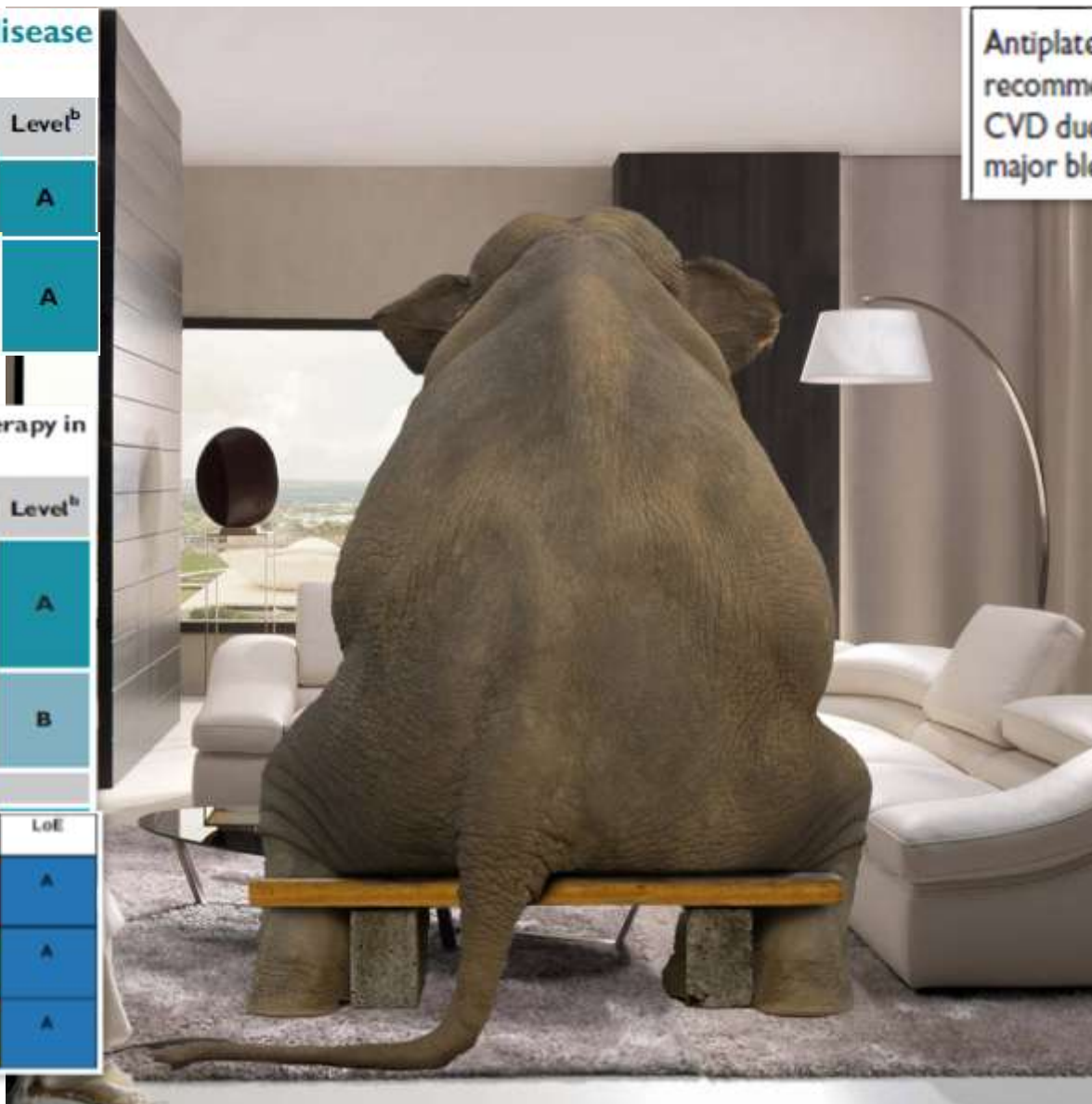
Antiplatelet therapy is not recommended in individuals without CVD due to the increased risk of major bleeding.

III

B

European Heart Journal (2016) 37, 2315–2381

Very low potential for benefit, high potential for harm





Ho smesso di
bere e fumare, vado
persino in palestra...
vivrò una settimana
di più, e in quella
settimana pioverà
a dirotto..

gettyimages
Ricci Galella

25 YEARS