

## COMMENT

## THE CHIMERIC NIHILISM OF GERIATRICS

*To the Editor:* Alfonso Quijano, the main character of the novel *Don Quijote de la Mancha*, is a madman who pursues a goal all of his own that others think of as futile.<sup>1</sup> Sisyphus, another hero of sorts, was condemned to the useless effort of eternally pushing a rock to the top of a hill only to see it roll down over and over again.<sup>2</sup> In contrast, Bellerophon, grandson of Sisyphus, became famous for a more goal-oriented and arguably more useful achievement; he hunted down and killed the Chimera (a frightful mythological monster whose body was composed of parts of several different animals).<sup>3</sup> Albert Camus wrote that even the most apparently useless activity might instead be directed toward high-level objectives that bear fruit in the long term and become a reason for inner satisfaction.<sup>2</sup>

As illustrated in the Thomas Cole's painting "The Voyage of Life," the boat that the voyager guides modifies its destiny according to changes in the landscape. That today large portions of the population get to grow old is a huge achievement that comes with a great responsibility of care and protection. *Ergo*, as geriatricians, we have clearly stated that older adults should receive care that is unique and holistic, which has strongly distinguished our approach from those of other specialties.

Clearly defined entities already exist that characterize the targets of beneficial interventions for older adults (e.g., disability, falls, delirium, depressive symptoms, quality of life).<sup>4-6</sup> Geriatricians have left a strong imprint on each of these examples by optimally describing stand-alone and accurately defined conditions.

Yet, in geriatrics, there are a number of chimeras, a mishmash of entities, perhaps as a result of difficulty understanding and defining geriatric problems; by forgetting the original call to pursue a career in older adult care, some professionals give birth to hybrids that mimic what other specialties commonly do with their "stand-alone disease approach." Using chimeras is, for geriatricians, a flawed way of revealing new paradigms. Creating chimeras is not different from Sisyphus's task; researchers can easily add new and different pieces over and over again, only to be forced to begin anew each time.

In this context, it is by no means trivial the attention that has been granted to the "p-hacking" problem. Chasing the chimeras in the different databases without a clear hypothesis while waiting for the longed-for " $P < .05$ " to make its appearance does not help in the battle for survival in geriatrics. Attributing a new name to a well-established negative condition is not a guarantee of novelty or clinical or research relevance. For example, we have long known that the physical and cognitive domains of the older individual are closely related. Do we need to develop new ways of

stating this? Do we need to operationalize conditions as "cognitive frailty" or "osteosarcopenia" to reinforce once more the association between the two? The urge to give a new name to something known for decades in geriatrics may simply indicate a weakness in spreading our ideas and evidence. Instead of generating further evidence, we make a name change in the false hope that the message will get through. We strive to obtain easy and immediate success by generating a chimera that will simply create confusion and misunderstandings, although every geriatrician knows (or should know) that chimeras are clinically irrelevant; they will not change geriatric practice and are conducive to a nihilism of sorts in our discipline: if everything goes, nothing really matters. Nihilism is a philosophical doctrine that denies the existence of several aspects of life.<sup>7</sup> For a nihilist, it is worthless to pursue anything if the result will not change. The lack of respect that the discipline of geriatrics has endured might be justified if geriatricians start chasing these mythological monsters, if they take up this kind of chimeric nihilism and forget the real tasks they are called for.

Some lucidity as to what the objective of our discipline should be is in order. It is pivotal to advance in the practical care of older adults without looking for vague, artificial, and contentious definitions that add nothing to what we already know.

Quoting Nietzsche, "When nihilism prevails in some disciplines, these will change their values and progress into a better future."<sup>7</sup>

Natalia Sánchez-Garrido, MD  
Geriatric Epidemiology Research Department, Instituto  
Nacional de Geriátria, Mexico City, Mexico

Matteo Cesari, MD, PhD  
Gérontopôle, Centre Hospitalier Universitaire de  
Toulouse, Toulouse, France  
Université de Toulouse III Paul Sabatier, Toulouse, France

Aldo Sgaravatti, MD  
Geriatrics Department, Universidad de la República,  
Montevideo, Uruguay

Elisa Zengarini, MD  
Institute of Gerontology and Geriatrics, Department of  
Medicine, University of Perugia, Perugia, Italy

Virgilio Moreira, MD, MSc  
Internal Medicine Department, Rio de Janeiro State  
University, Rio de Janeiro, Brazil

Miguel-Germán Borda, MD  
Aging Institute, Pontificia Universidad Javeriana, Bogotá,  
Colombia

Clemente Zúñiga-Gil, MD

*Internal Medicine and Geriatrics Department, Universidad Autónoma de Baja California, Tijuana, Baja California, Mexico*

*Mario Ulises Pérez-Zepeda, MD, PhD  
Geriatric Epidemiology Research Department, Instituto Nacional de Geriátría, Mexico City, Mexico*

## ACKNOWLEDGMENTS

**Conflict of Interest:** The editor in chief has reviewed the conflict of interest checklist provided by the authors and has determined that the authors have no financial or any other kind of personal conflicts with this paper.

**Author Contributions:** Sánchez-Garrido wrote the manuscript and gave substantial ideas of the text. Cesari improved the manuscript, gave substantial ideas, and supervised all stages of the manuscript writing. Sgaravatti, Zengarini, Moreira, Borda, Zúñiga-Gil gave substantial ideas for the manuscript. Pérez-Zepeda had the original idea and coordinated all stages of the manuscript writing.

**Sponsor's Role:** None.

## REFERENCES

1. Cervantes M. *Don Quijote de la Mancha*. Madrid: Alfaguara, 2013.
2. Camus A. *Le Mythe de Sisyphe*. Paris: Gallimard, 1942.
3. Graves R. *Les Myths Grecs*. London: Penguin Books, 1955.
4. Fairhall N, Sherrington C, Lord SR et al. Effect of a multifactorial, interdisciplinary intervention on risk factors for falls and fall rate in frail older people: a randomised controlled trial. *Age Ageing* 2014;43:616–622.
5. Holt R, Young J, Heseltine D. Effectiveness of a multi-component intervention to reduce delirium incidence in elderly care wards. *Age Ageing* 2013;42:721–727.
6. Martire LM, Schulz R, Reynolds CF III et al. Treatment of late-life depression alleviates caregiver burden. *J Am Geriatr Soc* 2010;58:23–29.
7. Nietzsche F. *Der Wille zur Macht*. Leipzig: Druck und Verlag von CG Naumann, 1901.

## RESEARCH

### REVASCULARIZATION IN INDIVIDUALS AGED 90 AND OLDER WITH CRITICAL LOWER LIMB ISCHEMIA

*To the Editor:* As a consequence of the rise in life expectancy, people aged 90 and older increasingly need evaluation for critical limb ischemia (CLI) and are potential candidates for infrainguinal revascularization.<sup>1</sup> These individuals typically have multilevel vascular lesions and severe vascular bed disease and are therefore likely to have cardiovascular comorbidity.<sup>2,3</sup> In this context, autologous vein bypass is considered the main treatment option, although thanks to technical advances, endovascular procedures may offer similar results with lower related morbidity.<sup>4,5</sup>

Few published series have studied the population aged 90 and older specifically.<sup>6</sup> The goal of the current study was to evaluate whether the revascularization approach in these individuals fulfills a set of security and efficacy criteria generated from surgical results in a validated historical

cohort for infrainguinal procedures in individuals with CLI.

The Society for Vascular Surgery (SVS) recently proposed a series of objective performance goals (OPGs)<sup>7,8</sup> generated from a historical cohort of individuals who had undergone autologous bypasses adjusted for risk subgroups obtained from randomized trials.<sup>9</sup> They allow the security and efficacy of new revascularization procedures in individuals with CLI to be evaluated using a noninferiority analysis, using the validated historical cohort as control group (Table 1). The results were analyzed according to the OPGs for CLI evaluation in individuals at high clinical risk of poor revascularization outcomes (aged >80, with trophic lesions) (N = 136 procedures).

A 30-day security OPG was considered to be fulfilled if the upper limit of the cohort's 95% confidence interval (95% CI) was below the reference OPG. For efficacy, OPGs were considered to be fulfilled if the lower limit of the cohort's 95% CI was above the reference OPG. Survival and limb salvage rates were calculated using the Kaplan–Meier method and compared using the log-rank test.

The local investigation ethics committee approved the trial protocol, which was conducted according to the most-recent amendments to the Declaration of Helsinki and in adherence to good clinical practice guidelines. Written informed consent was obtained from all participants. The study was registered on [www.clinicaltrials.gov](http://www.clinicaltrials.gov) ([www.ClinicalTrials.gov](http://www.ClinicalTrials.gov); identifier: NCT02517840).

Between 2002 and 2012, 53 individuals aged 90 and older were admitted to the Department of Angiology and Vascular Surgery, Getafe University Hospital, Getafe, Madrid, Spain, with CLI who were candidates for revascularization. The diseased limb was considered nonrevascularizable in 34 (64%) participants because of an unviable trophic or inaccessible diseased vascular bed; in 16 of these (30%), amputation was performed, and the other 18 (34%) were treated conservatively. The remaining 19 (36%) participants underwent infrainguinal revascularization procedures.

After excluding participants who required primary limb amputation, global limb salvation rate at 12 months was 79%; no statistically significant differences were observed between participants who underwent revascularization (80%) and those treated conservatively (84%) (hazard ratio (HR) = 0.95, 95% CI = 0.75–1.15, *P* = .10).

Twelve-month survival was 53%. The revascularization group had a lower survival rate (56%) than conservatively treated participants (64%), but the difference was not statistically significant (HR = 0.87, 95% CI = 0.72–1.12, *P* = .30). Survival rates were higher in the revascularized (56%, HR = 4, 95% CI = 2.7–5.8, *P* = .04) and conservatively treated participants (64%, HR = 4.5, 95% CI = 2.9–6.5, *P* = .02) than in those who underwent primary amputation (14%).

Security outcomes and OPGs at 30 days and efficacy outcomes and OPGs at 12 months in individuals who underwent revascularization are shown at Table 1.

The incidence of major adverse events and cardiovascular events at 30 days was greater, albeit nonsignificantly, in the cohort aged 90 and older than in the subgroup of